

# MASSACHUSETTS STANDARD FORM FOR MEDICATION PRIOR AUTHORIZATION REQUESTS

*\*Some plans might not accept this form for Medicare or Medicaid requests.*

This form is being used for:		
Check one:	<input type="checkbox"/> Initial Request	<input type="checkbox"/> Continuation/Renewal Request
Reason for request ( <i>check all that apply</i> ):	<input type="checkbox"/> Prior Authorization, Step Therapy, Formulary Exception <input type="checkbox"/> Quantity Exception <input type="checkbox"/> Specialty Drug <input type="checkbox"/> Other ( <i>please specify</i> ): _____	
Check if Expedited Review/Urgent Request:	<input type="checkbox"/> (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)	

A. Destination — Where this form is being submitted to; payers making this form available on their websites may prepopulate section A	
Health Plan or Prescription Plan Name: <b>Blue Cross Blue Shield of Massachusetts</b>	
Health Plan Phone: <b>1-800-366-7778</b>	Fax: <b>1-800-583-6289 (most requests; exceptions below)</b>

**For professionally administered medications (including buy & bill), fax to 1-888-641-5355. For BCBSMA employees, fax to 1-617-246-4013.**

B. Patient Information		
Patient Name:	DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
Member ID #:		

C. Prescriber Information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
<b>Prescribing Clinician or Authorized Representative Signature:</b>	
Date:	

D. Medication Information	
Medication being requested:	
Strength:	Quantity:
Dosing Schedule:	Length of Therapy:
Date Therapy Initiated:	
Is the patient currently being treated with the drug requested? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date started:
Dispense as Written (DAW) Specified? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rationale for DAW:	

E. Compound and Off Label Use	
Is Medication a Compound? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If Medication Is a Compound, List Ingredients:	
For Compound or Off Label Use, include citation to peer reviewed literature:	

(Continued on next page)

**F. Patient Clinical Information**

*\*Please refer to plan-specific criteria for details related to required information.*

Primary Diagnosis Related to Medication Request:

ICD Codes:

Pertinent Comorbidities:

*If Relevant to This Request:*

Drug Allergies:

Height:

Weight:

Pertinent Concurrent Medications:

Opioid Management Tools in Place:  Risk assessment  Treatment Plan  Informed Consent  Pain Contract  Pharmacy/Prescriber Restriction

Previous Therapies Tried/Failed:

**Previous Therapies**

Drug Name	Strength	Dosing Schedule	Date Prescribed	Date Stopped	Description of Adverse Reaction or Failure	Check if Sample
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>
						<input type="checkbox"/>

Are there contraindications to alternative therapies?  Yes  No

If yes, please list details:

Were nonpharmacologic therapies tried?  Yes  No

If yes, please list details:

**Relevant Lab Values**

Lab Name and Lab Value	Date Performed	Lab Name and Lab Value	Date Performed

If renewal, has the patient shown improvement in related condition while on therapy?  Yes  No  N/A

If yes, please describe:

Additional information pertinent to this request:

**Complete this section for Professionally Administered Medications (including Buy and Bill).**

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

Servicing Prescriber/Facility Name: \_\_\_\_\_  Same as Prescribing Clinician

Servicing Provider/Facility Address: \_\_\_\_\_

Servicing Provider NPI/Tax ID #: \_\_\_\_\_

Name of Billing Provider: \_\_\_\_\_

Billing Provider NPI #: \_\_\_\_\_

Is this a request for reauthorization?  Yes  No

CPT Code: \_\_\_\_\_ # of Visits: \_\_\_\_\_ J Code: \_\_\_\_\_ # of Units: \_\_\_\_\_

*Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.*