CLEAR FORM

# 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: | ☐ Initial Request ☐ Continuation/Renewal Request |
| Reason for Request *(Check all that apply)*: | ☐ Prior Authorization, Step Therapy, Formulary Exception<br>☐ Quantity Exception<br>☐ Specialty Drug<br>☐ Other *(Please specify)*: _____ |
| Check if Expedited Review/Urgent Request: | ☐ (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 as defined by the carrier.) |

| **A. Destination — *Where This Form Is Being Submitted to; Payers Making This Form Available on Their Websites May Prepopulate Section A*** | | |
|---|---|---|
| Health Plan Name: Harvard Pilgrim Health Plan | | |
| Health Plan Phone: 800-708-4414 | Fax: 617-673-0988 | Online Prior Authorization: https://point32health.promptpa.com |

| **B. Patient Information** | | |
|---|---|---|
| Patient Name: | DOB: | Member ID #: |
| Sex Assigned at Birth: ☐ Male ☐ Female ☐ "X" or Intersex | | |
| Current Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other | | |

*Plans do not discriminate based on race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).*

| **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): | |
| **Prescribing Clinician or Authorized Representative Signature:** | |
| Date: | |

| **D. Medication Information**<br>***For medications subject to step therapy protocol for which you are seeking an exception, please also complete Section F. For more information, refer to the health plan's coverage policies, member benefits, and medical necessity guidelines.*** | |
|---|---|
| Medication Being Requested: | |
| Strength: | Quantity: |
| Dosing Schedule: | Length of Therapy: |
| Date Therapy Initiated: | |
| Is the patient currently being treated with the drug requested? ☐ Yes ☐ No | If yes, date started: |
| Dispense as Written (DAW) Specified? ☐ Yes ☐ No | |
| Rationale for DAW: | |

| **E. Compound and Off Label Use** |
|---|
| Is medication a compound? ☐ Yes ☐ 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. Exceptions to Step Therapy

***Please complete the applicable section(s).***

Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to the member? ☐ Yes ☐ No

If yes, briefly describe details of contraindication, adverse reaction, or harm:

Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regiment? ☐ Yes ☐ No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen:

Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

If yes, please provide details for the previous trial(s):

**Drug Name:** _____ **Dates/Duration of Use:** _____

Did the member experience any of the following? ☐ Adverse Reaction ☐ Inadequate Response

Briefly describe details of adverse reaction or inadequate response:

**Drug Name:** _____ **Dates/Duration of Use:** _____

Did the member experience any of the following? ☐ Adverse Reaction ☐ Inadequate Response

Briefly describe details of adverse reaction or inadequate response:

Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in or physical or mental harm to the member? ☐ Yes ☐ No

If yes, briefly provide details of the adverse reaction or physical or mental harm:

## G. 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 |
|---|---|---|---|---|---|---|
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |
| | | | | | | ☐ |



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## G. Patient Clinical Information *(continued)*

Are there contraindications to alternative therapies? ☐ Yes ☐ No

If yes, please list details:

Were nonpharmacologic therapies tried? ☐ Yes ☐ No

If yes, provide 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.***