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Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

General Drug Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Please note: the requested drug may have a specific form that contains information pertinent to this PA request. Please see more drug-specific PA forms within the MassHealth Drug List at **www.mass.gov/druglist.**

In addition, the **Pediatric Behavioral Health Medication Initiative** requires prior authorization for pediatric members (generally members < 18 years of age) for certain behavioral health medication classes and/or specific medication combinations (i.e., polypharmacy) that have limited evidence for safety and efficacy in the pediatric population.

Additional information about medications and the **Pediatric Behavioral Health Medication Initiative**, including PA requirements, a complete list of all behavioral health medications, and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist**. The related PA form is available at: **Pediatric Behavioral Health Medication Initiative PA Request Form.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Drug name requested _____

Dose, frequency, and duration _____ Drug NDC (if known) or service code _____

Diagnosis and/or indication _____

Section I. Please complete the following for all requests.

1. Please indicate whether the request is for pharmacy or in-office billing. ☐ Pharmacy billing ☐ In-office billing
2. Has member tried other medications to treat this condition?
   - ☐ Yes. Provide the information below. You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).
   - ☐ No. Explain why not (attach a letter describing medical necessity as applicable). _____

   Drug name _____ Dates of use _____

   Dose and frequency _____

   Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

   Briefly describe details of adverse reaction, inadequate response, or other. _____

   Drug name _____ Dates of use _____

   Dose and frequency _____

   Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

   Briefly describe details of adverse reaction, inadequate response, or other. _____

Section II. Please complete the following as applicable for all requests.

Explain medical necessity of requested drug. _____

List all current medications. _____

Diagnostic studies and/or laboratory tests performed (include dates and results). _____

Other pertinent information. _____

Section III. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

Prescriber information

Last Name* _____ First Name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

** Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.).

Signature required _____

Printed name of prescribing provider _____ Date _____

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