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

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 provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Information about which drugs require PA can be found within the MassHealth Drug List at **www.mass.gov/masshealth**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.)
					f m

Member's place of residence ☐ home ☐ nursing facility

Height Weight

Medication information

Drug name requested | Dose, frequency, and duration | Drug NDC (if known) or service code

Diagnosis and/or indication

Goals of therapy for requested medication

Has member tried other medications to treat this condition?

☐ Yes. Provide the information to the right. You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

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.

☐ No. Explain why not.

Medication information (cont.)

Explain medical necessity of requested drug.

List all current medications.

Other pertinent information:

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

Pharmacy information

Name	Pharmacy provider no.	Telephone no.	Fax no.
	Optional		Optional
Address		City	State	Zip
				Optional

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.
Address			City	State	Zip
E-mail address			Telephone no.	Fax no.
Optional				

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):

Printed name of prescribing provider:

Date: