



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

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### 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

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### Medication information

Drug name requested \_\_\_\_\_  
Dose, frequency, and duration \_\_\_\_\_ Drug NDC (if known) or service code \_\_\_\_\_  
Diagnosis and/or indication \_\_\_\_\_

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### 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. \_\_\_\_\_  
\_\_\_\_\_

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

Explain medical necessity of requested drug. \_\_\_\_\_

\_\_\_\_\_

List all current medications. \_\_\_\_\_

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

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Other pertinent information. \_\_\_\_\_

\_\_\_\_\_

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**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*

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**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 \_\_\_\_\_