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).

☐ No. Explain why not.

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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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. ( )	
Address		City	State	Zip

Prescriber information

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

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date