



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

Brand-Name 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.

Prescribers must obtain PA from MassHealth for any brand-name multiple-source drug that has an FDA "A"-rated generic equivalent as identified by the **Approved Drug Products with Therapeutic Equivalence Evaluations** (also called the "Orange Book"). Additional 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		<input type="checkbox"/> home	<input type="checkbox"/> nursing facility		

Medication information

Brand-name drug requested	Dose, frequency, and duration of brand-name drug	Drug or service code																
Diagnosis pertinent to requested medication																		
Has member tried a generic product?																		
<input type="checkbox"/> Yes. Provide the following information.		<input type="checkbox"/> No. Explain why not.																
<table border="1"> <tr> <td>Drug name</td> <td></td> </tr> <tr> <td>Dates of generic use</td> <td>Dose and frequency</td> </tr> <tr> <td colspan="2">Did member experience any of the following?</td> </tr> <tr> <td colspan="2"> <input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other </td> </tr> <tr> <td colspan="2">Details of adverse reaction, inadequate response, or other:</td> </tr> <tr> <td colspan="2">_____</td> </tr> <tr> <td colspan="2">_____</td> </tr> <tr> <td colspan="2">_____</td> </tr> </table>		Drug name		Dates of generic use	Dose and frequency	Did member experience any of the following?		<input type="checkbox"/> Adverse reaction <input type="checkbox"/> Inadequate response <input type="checkbox"/> Other		Details of adverse reaction, inadequate response, or other:		_____		_____		_____		_____ _____ _____ _____ _____ _____
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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