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 ☐ home ☐ 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?

☐ Yes. Provide the following information.

Drug name	
Dates of generic use	Dose and frequency

Did member experience any of the following?

☐ Adverse reaction ☐ Inadequate response ☐ Other

Details of adverse reaction, inadequate response, or other: _____

☐ No. Explain why not.

_____

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