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 and Non-preferred Generic 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.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

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

Medication information

Drug requested ____

Dose, frequency, and duration ____

Drug NDC (if known) or service code ____

Diagnosis pertinent to requested medication ____

Section I. Please complete for brand-name requests.

Has the member tried a generic product therapeutically equivalent to the brand-name product requested?

☐ 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* ____________________________________

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☐ No. Explain why not. (Attach a letter with additional information regarding trials as applicable.)

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** Please provide supporting documentation (e.g., copies of medical records and/or office notes).*

Section II. Please complete for non-preferred generic requests.

Has the member tried a brand-name product therapeutically equivalent to the non-preferred generic product requested?

☐ Yes. Provide the following information.

Drug name ____________________ Dates of brand-name use ____________________

Dose and frequency ____

Did member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Details of adverse reaction, inadequate response, or other* ____________________

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☐ No. Explain why not. (Attach a letter with additional information regarding trials as applicable.)

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** Please provide supporting documentation (e.g., copies of medical records and/or office notes).*

Section III. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

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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*

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 ____________________