CLEAR FORM

MASSACHUSETTS STANDARD FORM FOR MEDICATION PRIOR AUTHORIZATION REQUESTS

*\*Some plans might not accept this form for Medicare or Medicaid requests.*

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| **This form is being used for:** | | | |
| Check one: | * Initial Request | | * Continuation/Renewal Request |
| Reason for request *(check all that apply)*: ☐ Prior Authorization, Step Therapy, Formulary Exception   * Quantity Exception * Specialty Drug * Other *(please specify)*: | | | |
| Check if Expedited Review/Urgent Request: | * (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.) | | |
|  | | | |
| **A. Destination — Where this form is being submitted to; payers making this form available on their websites may prepopulate section A** | | | |
| Health Plan or Prescription Plan Name: | | | |
| Health Plan Phone: | | Fax: | |
|  | | | |
| **B. Patient Information** | | | |
| Patient Name: | DOB: | | Gender: ☐ Male ☐ Female ☐ Unknown |
| Member ID #: | | | |
|  | | | |
| **C. Prescriber Information** | | | |
| Prescribing Clinician: | | Phone #: | |
| Specialty: | | Secure Fax #: | |
| NPI #: | | DEA/xDEA: | |
| Prescriber Point of Contact Name (POC) (if different than provider): | | | |
| POC Phone #: | | POC Secure Fax #: | |
| POC Email (not required): | | | |
| **Prescribing Clinician or Authorized Representative Signature:** | | | |
| Date: | | | |
|  | | | |
| **D. Medication Information** | | | |
| Medication Being Requested: | | | |
| Strength: | | Quantity: | |
| Dosing Schedule: | | Length of Therapy: | |
| Date Therapy Initiated: | | | |
| Is the patient currently being treated with the drug requested? ☐ Yes ☐ No If yes, date started: | | | |
| Dispense as Written (DAW) Specified? ☐ Yes ☐ No | | | |
| Rationale for DAW: | | | |
|  | | | |
| **E. Compound and Off Label Use** | | | |
| Is Medication a Compound? ☐ Yes ☐ No | | | |
| If Medication Is a Compound, List Ingredients: | | | |
| For Compound or Off Label Use, include citation to peer reviewed literature: | | | |

1 *(continued on next page)*

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| **F. Patient Clinical Information** | | | | | | | |
| ***\*Please refer to plan-specific criteria for details related to required information.*** | | | | | | | |
| Primary Diagnosis Related to Medication Request: | | | | | | | |
| ICD Codes: | | | | | | | |
| Pertinent Comorbidities: | | | | | | | |
| *If Relevant to This Request:* | | | | | | | |
| Drug Allergies: | | | | | | | |
| Height: | | | | Weight: | | | |
| Pertinent Concurrent Medications: | | | | | | | |
| Opioid Management Tools in Place: ☐ Risk assessment ☐ Treatment Plan ☐ Informed Consent ☐ Pain Contract ☐ Pharmacy/Prescriber Restriction | | | | | | | |
| Previous Therapies Tried/Failed: | | | | | | | |
| **Previous Therapies** | | | | | | | |
| Drug Name | Strength | Dosing Schedule | Date Prescribed | | Date Stopped | Description of Adverse Reaction or Failure | Check if Sample |
|  |  |  |  | |  |  | ☐ |
|  |  |  |  | |  |  | ☐ |
|  |  |  |  | |  |  | ☐ |
|  |  |  |  | |  |  | ☐ |
|  |  |  |  | |  |  | ☐ |
| Are there contraindications to alternative therapies? ☐ Yes ☐ No | | | | | | | |
| If yes, please list details: | | | | | | | |
| Were nonpharmacologic therapies tried? ☐ Yes ☐ No | | | | | | | |
| If yes, provide details: | | | | | | | |
| **Relevant Lab Values** | | | | | | | |
| Lab Name and Lab Value | Date Performed | | Lab Name and Lab Value | | | | Date Performed |
|  |  | |  | | | |  |
|  |  | |  | | | |  |
|  |  | |  | | | |  |
| If renewal, has the patient shown improvement in related condition while on therapy? ☐ Yes ☐ No ☐ N/A | | | | | | | |
| If yes, please describe: | | | | | | | |
| Additional information pertinent to this request: | | | | | | | |

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| **Complete this section for Professionally Administered Medications *(including Buy and Bill).*** |
| Start Date: End Date: Servicing Prescriber/Facility Name: ☐ Same as Prescribing Clinician  Servicing Provider/Facility Address: Servicing Provider NPI/Tax ID #: Name of Billing Provider: Billing Provider NPI #:  Is this a request for reauthorization? ☐ Yes ☐ No  CPT Code: # of Visits: J Code: # of Units: |

Providers should consult the health plan’s coverage policies, member benefits, and medical necessity guidelines to complete this form.

Providers may attach any additional data relevant to medical necessity criteria.

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