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: |
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| **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 ClinicianServicing Provider/Facility Address: Servicing Provider NPI/Tax ID #: Name of Billing Provider: Billing Provider NPI #: Is this a request for reauthorization? ☐ Yes ☐ NoCPT 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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