

Clinical Justification – Medication Prior Authorization Request Form

Fax: 1-866-305-5739 | Phone: 1-888-566-0008

Product Applicability: **MassHealth** **Well Sense**

PRESCRIBER INFORMATION

Name: _____ NPI#: _____ Specialty: _____

Office Contact: _____ Date: _____

Phone: _____ Fax: _____ Prescriber Signature (required): _____

Address: _____ City: _____ State: _____ Zip Code: _____

PATIENT INFORMATION

Name: _____

DOB: _____ Member BMCHP ID: _____

CLINICAL INFORMATION

Drug name/Strength/dosage form/quantity: _____ Directions: _____

Diagnosis/ICD-10 Codes: _____ Duration of Therapy: _____

<p>Reason for PA Request:</p> <p><input type="checkbox"/> New Start</p> <p><input type="checkbox"/> Continuation of Current Therapy:</p> <p>Start Date (mm/yy) : _____</p>	<p>Urgent: Member is at substantial risk for serious harm where the request for medication cannot wait for the standard review process.</p> <p style="text-align: right;"><input type="checkbox"/> Urgent</p>
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Medications History			
Medication (name & dose)	Start Date of Therapy	End Date of Therapy	Document Response/Outcome

Please provide the following information (if applicable):

Relevant Lab values: _____ Date: _____

Severity of Condition: Mild Moderate Severe

Does the member have swallowing difficulty due to a clinical condition Yes (*please describe below*) No

Additional information: (*Attach supporting clinical literature if request is for off-label indications or as applicable*)

For clinical policy details, please visit bmchp.org

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