BOSTON MEDICAL CENTER HEALTHNet PLAN

ENVISIONRx

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**:** _____

Reason for PA Request:	**Urgent: Member is at substantial risk for serious harm where the request for medication cannot wait for the standard review process.**
☐ New Start ☐ Continuation of Current Therapy: Start Date (mm/yy) :	☐ Urgent

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