



MASSACHUSETTS

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**Request for Outpatient Retail Pharmacy Prior Authorization**

Fax to: Clinical Pharmacy Program (800) 583-6289 or Web: <https://provider.express-path.com>.

We cannot process requests unless they contain <b>all</b> of the information requested below:	
<b>Patient Information (REQUIRED)</b>	
Name	
BCBSMA ID number	
Is the patient a BCBSMA employee? If yes, please fax request to: (617) 246-4013	Yes                      No
Date of Birth	
Patient's Diagnosis	
<b>Physician Information (REQUIRED)</b>	
Name	
Medical Specialty	
BCBSMA Provider number/NPI number	
Telephone Number	
Fax Number	
Is this fax number 'secure' for PHI receipt/transmission per HIPAA requirements? (circle one) Yes    No	
Contact Name (if different from physician)	
Please select <b>one</b> of the three following sections to complete, depending on the nature of your request for the above-named patient.	
<b>Formulary Exception Request</b>	
Name of non-covered drug you want to prescribe	
Reason for Individual Consideration Request (please check one): <input type="checkbox"/> Treatment failure with the following covered drugs in class: _____ <input type="checkbox"/> Documented adverse reaction to the following covered drugs: _____ <input type="checkbox"/> Other clinical reason (please specify) _____	
<b>Quality Care Dosing Override Request</b>	
Drug name, strength and quantity requested:	
Clinical reason for override (please specify)	
<b>Outpatient Retail Pharmacy Prior Authorization Request</b>	
Drug name:	
Start/End date (must be one year or less):	
Associated Co-morbid diagnosis:	
For Epogen®/Procrit® only:	GFR:
	Is patient certified ESRD with Medicare?    Yes    No
Prescriber Signature:	Date: