MEDICATION PRIOR AUTHORIZATION REQUEST FORM
CeltiCare Health Plan of Massachusetts
(Not for use with Biopharmaceutical Products*)

FAX this completed form to 866-399-0929

OR Mail requests to: **US Script PA Dept / 2425 West Shaw Avenue / Fresno, CA 93711**
Call 800-460-8988 to request a 72-hour supply of medication.

I. Provider Information	**II. Member Information**
Prescriber name (print):	Member name:
Office contact name:	Identification number:
Group name:	Group number:
Fax:	Date of Birth:
Phone:	Medication allergies:

III. Drug Information *(One drug request per form)*

Drug name and strength:	Dosage form:	Dosage Interval (sig):	Qty per Day:

Diagnosis relevant to ***this*** request:

Expected length of therapy:

Medication History for this Diagnosis

A. Is member currently treated on this medication?
☐ yes; How Long?_____ [go to item B] ☐ no [skip items B & C; go to item D]

B. Is this request for continuation of a previous approval?
☐ yes [go to item C] ☐ no [skip item C; go to item D]

C. Has strength, dosage, or quantity required per day increased or decreased?
☐ yes [go to item D] ☐ no [skip item D; indicate rationale for continuation in Section IV and submit form]

D. Please indicate previous treatment and outcomes below.

Drug Name (include strength and dosage)	**Dates of Therapy**	**Reason for Discontinuation**
1		
2		
3		
4		

NOTE: Confirmation of use will be made from member history on file; prior use of preferred drugs is a part of the exception criteria. The **CeltiCare Health Plan Preferred Drug List (PDL)** is available on the **CelticCare Health Plan** website at www.CeltiCarehealthplan.com.

IV. Rationale for Request / Pertinent Clinical Information (Required for all Prior Authorizations)

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

US Script will respond via fax or phone within 72 hours of receipt of all necessary information, except during weekends or holidays. Requests for prior authorization (PA) requests must include member name, ID#, and drug name. **Incomplete forms will delay processing**. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)

***Contact Caremark at 800-237-2767 for Biopharmaceutical Products.**