Universal Pharmacy Programs Request Form

TUFTS Health Plan

Pharmacy Utilization Management Department: 705 Mt. Auburn St. Watertown, MA 02472
- **Commercial:** Provider Services: (888) 884-2404 Fax: (617) 673-0988
- **Tufts Medicare Preferred HMO and PDP & Tufts Health Plan Senior Care Options (HMO SNP)**
  - Provider Relations: (800) 279-9022
  - Fax to (617) 673-0956

This form is only used for pharmacy requests that require prior authorization review by Tufts Health Plan.
For details of Tufts Health Plan Pharmacy Programs go to tuftshealthplan.com/providers.

For Tufts Medicare Preferred HMO, PDP and Tufts Health Plan Senior Care Options (HMO SNP) members, click here for criteria/request form for Medicare Part B vs Part D Coverage Determinations.

PATIENT INFORMATION

Name: _____ Date: _____

Member ID: _____ DOB: _____

Diagnosis: _____

Relevant Co-morbid Diagnoses: _____

Additional Comments/History: _____

PRESCRIBER INFORMATION

Name: _____ Specialty: _____

Tufts Health Plan Provider ID: _____ NPI: _____

Phone: _____ Fax: _____

Office Contact: _____

Prescriber Signature (required): _____

REQUESTED DRUG: Name and Strength:_____

Select one: ☐ Dispense As Written ☐ Generic Substitution Authorized

Dosage Form:_____ Quantity: _____

Duration of requested treatment: _____

CLINICAL JUSTIFICATION FOR REQUEST (if applicable)

Prior Medications	Adverse Reaction	Treatment Failure	Length of Therapy
	☐	☐	
	☐	☐	
	☐	☐	

EXPLANATION: Describe adverse reaction or treatment failure in detail. If not as effective, length of therapy on each drug and outcome.

_____

_____

_____

_____

(attach separate sheet if needed)

THIS SECTION APPLIES TO TUFTS MEDICARE PREFERRED HMO, PDP AND TUFTS HEALTH PLAN SENIOR CARE OPTIONS (HMO SNP) ONLY

1. Does the member's condition require expedited review (24 Hours)? ☐ **Yes*** ☐ **No**

* By checking the **"Yes" box and signing above**, I certify that the 72-hour standard review time may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

2. Does this member reside in long-term care? ☐ **Yes** ☐ **No**

Rationale for prior authorization or exception request. Check statement(s) that apply and include supporting documentation under Clinical Justification and Explanation sections on the left:

- ☐ Alternate formulary drug(s) contraindicated or previously tried, but with adverse outcome.
- ☐ Document drug name, adverse outcome, and, if therapeutic failure, length of therapy on drug.
- ☐ Complex patient with one or more chronic conditions is stable on current drug(s); high risk of significant adverse clinical outcome with medication change. Document anticipated significant adverse clinical outcome.
- ☐ Medical need for different dosage form and/or higher dosage. Document dosage form(s) and/or dosage(s) tried and explain medical reason.

3. Is this a request for a tier exception*? ☐ **Yes** ☐ **No**

* All formulary or preferred drug(s) on lower tier(s) contraindicated to the member's condition or were tried and failed, or not as effective as requested drug. Specialty tier is excluded from tiering exception.

Indication: _____