

Massachusetts
HIV Drug Assistance Program (MA HDAP)

Formulary Exclusion Override Form

Complete and return form via fax to 1-866-222-7508

The Massachusetts HIV Drug Assistance Program (HDAP) cannot cover the full cost of a medication for insured clients when it is not covered by a client's primary insurer. This form is to be used only when requesting exceptions from the HDAP Open Formulary Exclusion List.

Please use one form per patient and one drug per form. Fill out all applicable sections completely and legibly. Attach any documents that support the override request review (e.g., chart notes or lab data). Information on this form is protected health information under HIPAA.

Date of Request: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____

HDAP ID #: _____ Date of Birth: _____

HEALTHCARE PROVIDER INFORMATION

Last Name: _____ First Name: _____

Provider NPI: _____ Specialty: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Provider Phone: _____ Provider Fax: _____

DRUG INFORMATION

Drug Name: _____ NDC: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

☐ New Therapy ☐ Renewal If Renewal, date therapy initiated: _____

Last Name: _____ First Name: _____

1. What is the patient's diagnosis and ICD-10 code (if applicable)?

2. Please provide clinical justification for requested medication (provide as much detail as possible, and include any relevant clinical documentation, such as lab results and progress notes, with your submission):

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature: _____ Date: _____
(required)

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