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Pharmacy Selection Form

Controlled Substance Management Program

Use this form to request a different primary pharmacy from the one that MassHealth assigned to you upon enrollment into the Controlled Substance Management Program (CSMP) or to request a different pharmacy after you have been enrolled. Until MassHealth notifies you that your request has been approved, you must continue to use your current (or MassHealth-assigned) primary pharmacy.

Reminder: You can request a change in your pharmacy no more than once per year, unless the primary pharmacy is unable to address due to a change in your residence, your medical condition, or the primary pharmacy's business practices.

To request a different pharmacy, fill out the information below, and mail or fax this form to:

MassHealth Drug Utilization Review
Program P.O. Box 2586
Worcester, MA 01613-2586
Fax: (877) 208-7428

Member Information

Your Name: _____ Your MassHealth ID Number: _____

Name and Address of Current Pharmacy

_____

_____

_____

Name and Address of New Pharmacy

_____

_____

_____

Reason for change in your primary pharmacy: _____

Effective Date

Please enter the requested effective date of the change in your primary pharmacy. Please allow four business days for mailing and processing. We will send you a letter confirming your selection. Until MassHealth notifies you that your request has been approved, you must continue to use your current (or MassHealth-assigned) primary pharmacy.

Requested Effective Date: _____

Member Authorization: I understand that I may not change my primary pharmacy again for at least one year from the date of signature below, unless for one of the reasons listed above.

_____

Your Signature Date