



Prior Authorization Request Administrative Information

Member information

Last name First name MI

Member ID Date of birth

Sex assigned at birth Female Male "X" or Intersex

Current gender Female Male Transgender male Transgender female Other

Place of residence Home Nursing facility Other

Race Ethnicity

Preferred spoken language Preferred written language

MassHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping).

Plan contact information

Please indicate the member's MassHealth Plan and fax or submit this completed and signed form according to the Plan's contact information below.

MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, and Children's Medical Security Plan

MassHealth Drug Utilization Review Program

Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318

MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)

Fallon Health

Online Prior Authorization: go.covermy meds.com/OptumRx

Online Prior Authorization: providerportal.surescripts.net/ProviderPortal/optum

Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033

Health New England

Online Prior Authorization: go.covermy meds.com/OptumRx

Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545

Mass General Brigham Health Plan

Online Prior Authorization (Pharmacy Benefit Reviews): go.covermy meds.com/OptumRx

Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555

Online Prior Authorization (Medical Specialty Reviews): provider.massgeneralbrighamhealthplan.org

Medical Specialty Reviews: Fax: (888) 656-6671 - Tel: (833) 895-2611

Tufts Health Plan

Online Prior Authorization: point32health.promptpa.com

Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985

WellSense Health Plan

Online Prior Authorization: wellsense.org/providers/ma/pharmacy/prior-authorizations

Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

Anticonvulsant Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about anticonvulsants and the **Pediatric Behavioral Health Medication Initiative**, including PA requirements, a complete list of all behavioral health medications, and preferred products, can be found within the MassHealth Drug List at www.mass.gov/druglist. The related PA form is available at: **Pediatric Behavioral Health Medication Initiative PA Request Form**.

Medication information

Medication requested (Check one or all that apply.)

- | | |
|--|---|
| <input type="checkbox"/> brivaracetam solution, tablet | <input type="checkbox"/> Nayzilam (midazolam nasal spray) >10 units/30 days |
| <input type="checkbox"/> carbamazepine 200 mg chewable tablet | <input type="checkbox"/> oxcarbazepine extended-release |
| <input type="checkbox"/> Diacomit (stiripentol) | <input type="checkbox"/> perampanel |
| <input type="checkbox"/> diazepam rectal gel > 5 kits (10 syringes)/30 days | <input type="checkbox"/> pregabalin > 600 mg/day |
| <input type="checkbox"/> Elepsia XR (levetiracetam extended-release) | <input type="checkbox"/> rufinamide |
| <input type="checkbox"/> Epidiolex (cannabidiol) | <input type="checkbox"/> Sympazan (clobazam film) |
| <input type="checkbox"/> eslicarbazepine | <input type="checkbox"/> tiagabine |
| <input type="checkbox"/> Fintepla (fenfluramine) | <input type="checkbox"/> topiramate 50 mg sprinkle capsule |
| <input type="checkbox"/> gabapentin >3600 mg/day | <input type="checkbox"/> topiramate extended-release capsule [Trokendi XR] |
| <input type="checkbox"/> Lamictal XR starter kit, lamotrigine extended-release | <input type="checkbox"/> topiramate extended-release sprinkle capsule |
| <input type="checkbox"/> lamotrigine orally disintegrating tablet (ODT), ODT starter kit | <input type="checkbox"/> topiramate solution |
| <input type="checkbox"/> lamotrigine tablet starter kit | <input type="checkbox"/> Valtoco (diazepam nasal spray) >10 units/30 days |
| <input type="checkbox"/> Libervant (diazepam buccal film) > 10 units/30 days or ≥ 6 years of age | <input type="checkbox"/> vigabatrin powder packet, tablet |
| <input type="checkbox"/> levetiracetam tablet for oral suspension | <input type="checkbox"/> Vigafyde (vigabatrin solution) |
| <input type="checkbox"/> Motpoly XR (lacosamide extended-release capsule) | <input type="checkbox"/> Xcopri (cenobamate) |
| | <input type="checkbox"/> Zonisade (zonisamide suspension) |
| | <input type="checkbox"/> Ztalmy (ganaxolone) |
| | <input type="checkbox"/> Other* <input type="text"/> |

Dose, frequency, and duration of medication requested

Drug NDC (if known) or service code

** If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).*

Indication (Check all that apply or include ICD-10 code, if applicable.)

- | | | |
|--|--|--|
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Epilepsy or seizure disorder | <input type="checkbox"/> Lennox-Gastaut syndrome |
| <input type="checkbox"/> Cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) (provide documentation of genetic testing) | Type <input type="text"/> | <input type="checkbox"/> Migraine prophylaxis |
| <input type="checkbox"/> Diabetic peripheral neuropathy | <input type="checkbox"/> Epilepsy associated with tuberous sclerosis complex | <input type="checkbox"/> Pain associated with trigeminal neuralgia |
| <input type="checkbox"/> Dravet syndrome | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Postherpetic neuralgia |
| | <input type="checkbox"/> Infantile spasms | <input type="checkbox"/> Other <input type="text"/> |

Please list all other medications currently prescribed for the member for this indication.

[Empty text box for listing other medications]

Please indicate prescriber specialty below.

Neurology Psychiatry Other

[Empty text box for prescriber specialty]

If prescriber is not a specialist, please attach consult notes from specialist.

For mid-level practitioners (e.g., nurse practitioners, physician assistants), please provide the name and specialty of the collaborating physician, if applicable.

[Empty text box for collaborating physician information]

Is this member a referral candidate for care coordination? Yes No

If yes, MassHealth will offer care coordination services to this member. Please describe which additional behavioral health services would be beneficial. *Please inform the member, parent, or legal guardian to expect outreach from a MassHealth representative of care coordination services.*

[Empty text box for behavioral health services description]

Section I. Please complete for all requests as needed.

Please provide the following information regarding previous trials.*

1. Drug	[Empty text box]	Dates of Use	[Empty text box]	Outcome	[Empty text box]
2. Drug	[Empty text box]	Dates of Use	[Empty text box]	Outcome	[Empty text box]
3. Drug	[Empty text box]	Dates of Use	[Empty text box]	Outcome	[Empty text box]
4. Drug	[Empty text box]	Dates of Use	[Empty text box]	Outcome	[Empty text box]

*Attach a letter with additional information regarding medication trials as applicable.

Section II. Please also complete for requests for carbamazepine 200 mg chewable tablet, Elepsia XR, Lamictal XR starter kit, lamotrigine extended-release, lamotrigine tablet starter kit, levetiracetam tablet for oral suspension, Motpoly XR, oxcarbazepine extended-release, topiramate solution, Vigafyde, and Zonisade.

Please provide medical necessity for the use of the requested formulation instead of the respective formulation(s) available without prior authorization. For Motpoly XR and Vigafyde, please also provide the member's current weight.

[Empty text box for medical necessity]

Section III. Please complete for requests for gabapentin containing agents > 3600 mg/day and pregabalin containing agents > 600 mg/day.

Please provide clinical rationale for exceeding the maximum daily dose limit.

[Empty text box for clinical rationale]

Section IV. Please complete for requests for Diacomit.

1. Has the member experienced an inadequate response or adverse reaction to other anticonvulsants?
- Yes. Please complete Section I above.
- No. Explain why other anticonvulsants have not been tried.

2. Will the requested agent be used in combination with clobazam? Yes No

Section V. Please also complete for requests for topiramate 50 mg sprinkle capsule.

Please provide medical necessity for the use of the requested formulation instead of topiramate sprinkle capsule 15 mg or 25 mg available without prior authorization, and topiramate solution.

Section VI. Please complete for requests for lamotrigine ODT.

1. Does the member have a medical condition in which they are not able to swallow pills?
- Yes. Please describe. No
2. Has the member experienced an inadequate response or adverse reaction to lamotrigine dispersible tablets?
- Yes. Please describe trial below.

Dose and frequency Dates of Use Outcome

- No. Explain why lamotrigine dispersible tablets have not been tried.

Section VII. Please complete for requests for diazepam rectal gel (> 5 kits/month), Libervant (> 10 units/30 days), Nayzilam (> 10 units/30 days), and Valtoco (> 10 units/30 days).

1. Is the diagnosis for as needed (intermittent) treatment of acute seizure clusters that are distinct from a member's usual seizure pattern? Yes No
2. Please describe the medical necessity for use over quantity limits.

Section VIII. Please complete for requests for Libervant for members ≥ six years of age.

1. Is the diagnosis for as needed (intermittent) treatment of acute seizure clusters that are distinct from a member's usual seizure pattern? Yes No
2. Has the member experienced an inadequate response or adverse reaction to Valtoco?
- Yes. Please describe trial below.

Dose and frequency Dates of Use Outcome

- No. Explain why Valtoco has not been tried.

Section IX. Concomitant gabapentin and pregabalin for all formulations. Complete this section for all members, if request will result in prescription of concomitant gabapentin and pregabalin.

Please document complete treatment plan.

1. gabapentin dose/frequency Indication
2. pregabalin dose/frequency Indication
3. Other(s)

Please document clinical rationale for concomitant use of gabapentin and pregabalin for this member.

Please document monotherapy trials (include dose/frequency, dates/duration of use, and outcome) with gabapentin and pregabalin.*

Has the member experienced an inadequate response or adverse reaction to at least two other alternative agents for the requested indication(s)?

- Yes. Please complete Section I above.
 No. Explain why other alternative agents have not been tried.

Section X. Please complete and provide documentation for exceptions to step therapy.

1. Is the alternative drug required under the step therapy protocol contraindicated, or will likely cause an adverse reaction in, or physical or mental harm to, the member? Yes No

If yes, briefly describe details of contraindication, adverse reaction, or harm.

2. Is the alternative drug required under the step therapy protocol expected to be ineffective based on the known clinical characteristics of the member and the known characteristics of the alternative drug regimen?

Yes No

If yes, briefly describe details of known clinical characteristics of member and alternative drug regimen.

3. Has the member previously tried the alternative drug required under the step therapy protocol, or another alternative drug in the same pharmacologic class or with the same mechanism of action, and such alternative drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event?

Yes No

If yes, please provide details for the previous trial.

Drug name Dates/duration of use

Did the member experience any of the following? Adverse reaction Inadequate response

over

Briefly describe details of adverse reaction or inadequate response.

[Empty text box for adverse reaction details]

4. Is the member stable on the requested prescription drug prescribed by the health care provider, and switching drugs will likely cause an adverse reaction in, or physical or mental harm to, the member?

Yes. Please provide details.

[Empty text box for details if Yes]

No

*Attach a letter with additional information regarding medication trials as applicable.

MassHealth Pediatric Behavioral Health Medication Initiative

Please fill out all the sections below, as applicable, for pediatric members only. You may also use the Pediatric Behavioral Health Medication Initiative PA Request Form if the member is prescribed other behavioral health medications.

Section I. Please complete for all requests for medications subject to the Pediatric Behavioral Health Medication Initiative for members < 18 years of age.

Please document complete treatment plan listing all requested agents (include all behavioral health agents, corresponding strength, dose, directions of use and indication(s) or ICD-10 code(s), if applicable, for each medication(s)).

1. Medication name	<input type="text"/>	Dose/frequency	<input type="text"/>	Indication	<input type="text"/>
2. Medication name	<input type="text"/>	Dose/frequency	<input type="text"/>	Indication	<input type="text"/>
3. Medication name	<input type="text"/>	Dose/frequency	<input type="text"/>	Indication	<input type="text"/>
4. Medication name	<input type="text"/>	Dose/frequency	<input type="text"/>	Indication	<input type="text"/>
5. Medication name	<input type="text"/>	Dose/frequency	<input type="text"/>	Indication	<input type="text"/>
6. Medication name	<input type="text"/>	Dose/frequency	<input type="text"/>	Indication	<input type="text"/>
7. Other(s)	<input type="text"/>				

Is the member currently in an acute care setting?

Yes (Inpatient) Yes (Community Based Acute Treatment)

Yes (Partial Hospitalization) No

For members who are in an acute care setting, please document the outpatient prescriber after discharge.

Prescriber name

Contact information

Has the member been hospitalized for a psychiatric condition within the past three months?

Yes. Please document dates of hospitalization within the past three months.

No

On the current regimen, is the member considered to be a severe risk of harm to self or others?

Yes. Please provide details.

No

For regimens including an antipsychotic, are appropriate safety screenings and monitoring being conducted (e.g., weight, metabolic, movement disorder, cardiovascular, and prolactin-related effects)?

Yes No. Please explain.

Has informed consent from a parent or legal guardian been obtained?* Yes No

Please indicate prescriber specialty below.

Psychiatry Neurology Other

Specialist consult details (if the prescriber submitting the request is not a specialist)

Name(s) of the specialist(s) Date(s) of last visit or consult

Contact information

For mid-level practitioners (e.g., nurse practitioners, physician assistants), please provide the name and specialty of the collaborating physician, if applicable.

Please document member custody status.

Parent/Guardian Department of Children and Families (DCF)

Please document member placement status.

Home with Parent/Guardian Foster Care Residential Treatment Facility

Uncertain Other

Please document agency involvement.

DCF Department of Mental Health (DMH) Department of Developmental Services (DDS)

Department of Youth Services (DYS)

Is the member/family currently receiving appropriate psychotherapeutic and/or community based services for the targeted clinical mental health related concerns (e.g., Applied Behavioral Analysis, Children's Behavioral Health Initiative, school interventions, specialized placement)?

Yes. Please document details of interventions below, if applicable. No

Psychiatric care provided is coordinated with other psychotherapeutic and community based services. Yes No

* Sample informed consent form available on the MassHealth PBHMI Information webpage. For additional information go to <https://www.mass.gov/info-details/pediatric-behavioral-health-medication-initiative-pbhmi-information>.

Please complete for members who have been on one of the following for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation): a polypharmacy regimen, members < six years of age who have been on an applicable behavioral health medication, and members < ten years of age who have been on an antipsychotic.

Have previous efforts to reduce or simplify the regimen in the past 24 months resulted in symptom exacerbation? Yes No

The family or caregiver does not support the regimen change at this time due to risk of exacerbation.

Yes No

Is there another significant barrier for therapy discontinuation? Yes No

If yes, please explain.

Section II. Mood Stabilizer Polypharmacy. Complete this section for all members < 18 years of age, if request will result in prescription of three or more mood stabilizers for ≥ 60 days within a 90-day period (agents considered to be used only for seizure diagnoses are not included).

Please document if monotherapy trials (include drug name, dates/duration of use, and outcome) with mood stabilizers were tried before prescribing polypharmacy with three or more mood stabilizers in this member.*

Please document the treatment plans for medication regimen simplification (e.g., dose consolidation, frequency reduction) or medical necessity for continuation of a complex medication regimen.

Has the member been on a mood stabilizer polypharmacy regimen for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation)?

Yes. Please complete the applicable question in Section I. No

**Attach a letter with additional information regarding medication trials as applicable.*

Section III. Mood Stabilizer Request for Members < six years of age (agents considered to be used only for seizure diagnoses are not included).

Please document any previous medication trial(s). Include the drug name, dates/duration of use, and outcome.*

Please document clinical rationale for use of a mood stabilizer for this member < six years of age.

Has the member been on the requested agent for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation)? Yes. Please complete the applicable question in Section I. No

**Attach a letter with additional information regarding medication trials as applicable.*

Section IV. Multiple Behavioral Health Medications.

Complete this section for all members < 18 years of age if request will result in prescriptions of four or more behavioral health medications within a 45-day period if one of the following is included: an antipsychotic, a benzodiazepine, divalproex/valproate, lithium, or a tricyclic antidepressant.

Also complete this section for all members < 18 years of age if request will result in prescriptions of five or more behavioral health medications within a 45-day period. For a complete list of all behavioral health medications, please refer to the MassHealth Pediatric Behavioral Health Medication Initiative.

Please document monotherapy trials (include drug name, dates/duration of use, and outcome) tried before prescribing a polypharmacy regimen for this member.*

Please document the treatment plans for medication regimen simplification (e.g., dose consolidation, frequency reduction) or medical necessity for continuation of a complex medication regimen

Has the member been on the requested polypharmacy regimen for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation)? Yes. Please complete the applicable question in Section I. No

**Attach a letter with additional information regarding medication trials as applicable.*

Please continue to next page and complete Prescriber and Provider Information section.

Prior Authorization Request Prescriber and Provider Information

Prescriber information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
		Zip	<input type="text"/>		
E-mail address	<input type="text"/>				
Telephone No.*	<input type="text"/>				
Fax No.* (Please provide fax number for PA response notification.)	<input type="text"/>				

* Required

Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
		No. of units	<input type="text"/>		

Provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am either the prescribing provider or duly authorized to act on behalf of the provider identified in the Prescriber information section of this form. Any attached statement on letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Signature of provider or individual duly authorized to act on behalf of the provider:

Printed legal name and title of signatory above

<input type="text"/>	Date	<input type="text"/>
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(The form can either be signed by hand and then scanned, or it can be signed electronically using DocuSign or Adobe Sign. For electronic signatures, the signer can upload a picture of their wet signature. The typed text of a signature is not an acceptable form of an electronic signature.)