



# 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](http://go.covermy meds.com/OptumRx)

Online Prior Authorization: [providerportal.surescripts.net/ProviderPortal/optum](http://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](http://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](http://go.covermy meds.com/OptumRx)

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

Online Prior Authorization (Medical Specialty Reviews): [provider.massgeneralbrighamhealthplan.org](http://provider.massgeneralbrighamhealthplan.org)

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

**Tufts Health Plan**

Online Prior Authorization: [point32health.promptpa.com](http://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](http://wellsense.org/providers/ma/pharmacy/prior-authorizations)

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

# Pediatric Behavioral Health Medication Initiative

## 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.

The **Pediatric Behavioral Health Medication Initiative** requires prior authorization for pediatric members (generally members < 18 years of age) for certain behavioral health medication classes and/or specific medication combinations (i.e. polypharmacy) that have limited evidence for safety and efficacy in the pediatric population. For a comprehensive medication list and additional information about the **Pediatric Behavioral Health Medication Initiative**, including PA requirements and preferred products please refer to the MassHealth Drug List at [www.mass.gov/druglist](http://www.mass.gov/druglist).

**Please refer to the following table for guidance on filling out this PA form. Complete Section I, and all pertinent Sections as described below.**

<b>For all requests, complete Section I in its entirety.</b>	
Next, please complete all pertinent Sections as described below.	
<b>Polypharmacy Request Within the Same Medication Class</b> [e.g., regimen includes more than one antidepressant, benzodiazepine, cerebral stimulant, mood stabilizer (agents considered to be used only for seizure diagnoses are not included)]	Section II
<b>Antipsychotic Polypharmacy Request</b>	Section III
<b>Behavioral Health Medication Request for Members &lt; six years of age</b> [e.g., antidepressant, armodafinil, atomoxetine, benzodiazepine, buspirone, donepezil, memantine, meprobamate, modafinil, mood stabilizer (agents considered to be used only for seizure diagnoses are not included), naltrexone, prazosin, viloxazine, or xanomeline/trospium]	Section IV
<b>Antipsychotic Request for Members &lt; ten years of age</b>	Section V
<b>Alpha<sub>2</sub> Agonist or Cerebral Stimulant Request for Members &lt; three years of age</b>	Section VI
<b>Hypnotic Request for Members &lt; six years of age</b>	Section VII
<b>Request for Members on Multiple Behavioral Health Medications</b>	Section VIII
<b>Request for Non-Preferred Drug Products</b>	Section IX
<b>Request for Exceptions to Step Therapy</b>	Section X

**Thank you for helping to ensure that MassHealth pediatric members receive medically necessary behavioral health medications that are safe, effective, and optimize patient care.**

## Medication information

### 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

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

If yes, MassHealth will offer this member care coordination services. 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.*

\* 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. Polypharmacy within the same medication class (e.g., antidepressants, benzodiazepines, cerebral stimulants, mood stabilizers [agents considered to be used only for seizure diagnoses are not included]). Complete this section for all members < 18 years of age if request will result in polypharmacy within the same medication class.**

Please document if monotherapy trials (include drug name, dates/duration of use, and outcome) were tried before prescribing polypharmacy with two or more agents within the same medication class for this member.\*\*

Drug name

Dates/duration of use

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

Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

Drug name  Dates/duration of use

Did the member experience any of the following?  Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, contraindication, or other.

Other(s)

Please document clinical rationale for polypharmacy within the same medication class 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 an antidepressant or 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.*

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**Section III. Antipsychotic Polypharmacy. Complete this section for all members < 18 years of age if request will result in prescription of two or more antipsychotics for ≥ 60 days within a 90-day period.**

Please select the stage of treatment and clinical rationale for antipsychotic polypharmacy.

**Acute stage** (initiation of antipsychotic treatment likely with subsequent dose adjustments to maximize response and minimize side effects)

Member experienced an inadequate response or adverse reaction to two monotherapy trials with antipsychotics.

Drug name 1  Dates/Duration of use

Drug name 2  Dates/Duration of use

Member is transitioning from one antipsychotic to the other.

Other, please explain.

**Maintenance stage** (response to antipsychotic treatment with goal of remission or recovery)

1. Is the regimen effective, therapy benefits outweigh risks, and appropriate monitoring is in place?  
 Yes  No

2. Has the member been on an antipsychotic 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

**Discontinuation stage** (clinically indicated that the antipsychotic regimen can likely be successfully tapered)

Member is transitioning from one antipsychotic to the other.

Member is tapering antipsychotic. Please describe taper plan including duration.

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**Section IV. Behavioral Health Medication (e.g., antidepressant, armodafinil, atomoxetine, benzodiazepine, buspirone, donepezil, memantine, meprobamate, modafinil, mood stabilizer [agents considered to be used only for seizure diagnoses are not included], naltrexone, prazosin, viloxazine, or xanomeline/trospium) for members < six years of age.**

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


Please document clinical rationale for use of an antidepressant, armodafinil, atomoxetine, benzodiazepine, buspirone, donepezil, memantine, meprobamate, modafinil, mood stabilizer, naltrexone, prazosin, or viloxazine 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.*

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**Section V. Antipsychotic Request for Members < ten years of age.**

Please select the stage of treatment and clinical rationale for use of an antipsychotic for this member < ten years of age.

- Acute stage** (initiation of antipsychotic treatment likely with subsequent dose adjustments to maximize response and minimize side effects)
- Maintenance stage** (response to antipsychotic treatment with goal of remission or recovery)
  1. Is the regimen effective, therapy benefits outweigh risks, and appropriate monitoring is in place?  
 Yes  No
  2. Has the member been on an antipsychotic 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
- Discontinuation stage** (clinically indicated that the antipsychotic regimen can likely be successfully tapered)
  - Member is transitioning from one antipsychotic to the other.
  - Member is tapering antipsychotic. Please describe taper plan including duration.


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**Section VI. Alpha<sub>2</sub> Agonist or Cerebral Stimulant Request for Members < three years of age.**

Please document any previous medication trial(s). Include drug name, dates/duration of use, and outcome. For requests for an amphetamine product, include drug name, dates/duration of use, and outcome to a trial with a methylphenidate product.\*\*


Please document clinical rationale for use of an alpha2 agonist and/or cerebral stimulant for this member < three years of age.

[Empty text box]

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

**Section VII. Hypnotic Request for Members < six years of age.**

Please document if member has other behavioral health comorbidities (e.g., anxiety, depression, ADHD).

[Empty text box]

Please document medication trials with melatonin and/or clonidine, if clinically appropriate. Include drug name, dates/duration of use, and outcome.\*\*

[Empty text box]

Please document behavioral interventions (e.g., bedtime routine, extinction, fading, strategic napping, positive reinforcement, regular sleep-wake cycles, sleep restrictions, relaxation techniques).

[Empty text box]

Please document clinical rationale for the use of a hypnotic agent for this member < six years of age.

[Empty text box]

Has the member been on the requested hypnotic 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 VIII. 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.\*\*

[Empty text box]

Please document clinical rationale for use of multiple behavioral health medications for this member < 18 years of age.

[Empty text box]

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.*

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**Section IX. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.**

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

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**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

Briefly describe details of adverse reaction or inadequate response.

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.

No

# 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.)