



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

Antidepressant 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 antidepressants 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

- | | | |
|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> amoxapine | <input type="checkbox"/> Drizalma (duloxetine sprinkle capsule) | <input type="checkbox"/> paroxetine controlled-release |
| <input type="checkbox"/> Auvelity (dextromethorphan/bupropion) | <input type="checkbox"/> duloxetine 40 mg capsule | <input type="checkbox"/> protriptyline |
| <input type="checkbox"/> bupropion XL > 1 unit/day | <input type="checkbox"/> Emsam (selegiline) | <input type="checkbox"/> Raldesy (trazodone solution) |
| <input type="checkbox"/> bupropion hydrochloride extended-release 450 mg tablet | <input type="checkbox"/> escitalopram capsule | <input type="checkbox"/> sertraline capsule |
| <input type="checkbox"/> citalopram capsule | <input type="checkbox"/> Exxua (gepirone) | <input type="checkbox"/> Spravato (esketamine) (Section VIII) |
| <input type="checkbox"/> clomipramine | <input type="checkbox"/> Fetzima (levomilnacipran) | <input type="checkbox"/> trazodone 300 mg tablet |
| <input type="checkbox"/> desipramine | <input type="checkbox"/> fluoxetine 60 mg tablet | <input type="checkbox"/> trimipramine |
| <input type="checkbox"/> desvenlafaxine extended-release | <input type="checkbox"/> fluoxetine 90 mg delayed-release capsule | <input type="checkbox"/> Trintellix (vortioxetine) |
| <input type="checkbox"/> desvenlafaxine succinate extended-release 25 mg, 50 mg tablet > 1 unit/day | <input type="checkbox"/> fluvoxamine extended-release | <input type="checkbox"/> venlafaxine besylate extended-release tablet |
| <input type="checkbox"/> desvenlafaxine succinate extended-release 100 mg tablet > 4 units/day | <input type="checkbox"/> imipramine pamoate tablet | <input type="checkbox"/> venlafaxine hydrochloride extended-release tablet |
| | <input type="checkbox"/> Ketalar (ketamine injection) ^{MB} | <input type="checkbox"/> vilazodone |
| | <input type="checkbox"/> Marplan (isocarboxazid) | <input type="checkbox"/> Zurzuvae (zuranolone) |
| | <input type="checkbox"/> mirtazapine orally | <input type="checkbox"/> Other* <input type="text"/> |
| | <input type="checkbox"/> disintegrating tablet | |
| | <input type="checkbox"/> olanzapine/fluoxetine | |

* 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).

^{MB} This drug is available through the health care professional who administers the drug or in an outpatient or inpatient hospital setting. MassHealth does not pay for this drug to be dispensed through the retail pharmacy. If listed, PA does not apply through the acute hospital inpatient setting, unless on the APAD/APEC carve-out drug list, or in the emergency, trauma, or urgent acute hospital outpatient settings. Please refer to 130 CMR 433.408 for PA requirements for other health care professionals. Notwithstanding the above, this drug may be an exception to the unified pharmacy policy; please refer to respective MassHealth Accountable Care Partnership Plans (ACPPs) and Managed Care Organizations (MCOs) for PA status and criteria, if applicable.

Dose, frequency, and duration of medication requested

Please indicate billing preference. Pharmacy Prescriber in-office Hospital outpatient

If applicable, please also complete section for professionally administered medications at end of form.

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

- | | |
|----------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Major depressive disorder (MDD) | <input type="checkbox"/> Panic disorder |
| <input type="checkbox"/> Obsessive-compulsive disorder | <input type="checkbox"/> Postpartum depression |
| <input type="checkbox"/> Premenstrual dysphoric disorder | <input type="checkbox"/> Other (describe) <input type="text"/> |

Please list all other psychotropic medications currently prescribed for the member.

[Empty text box for listing psychotropic medications]

Has member been hospitalized for this condition?

Yes. Dates of most recent hospitalization [] No

Is the member under the care of psychiatrist? Yes No

Name of psychiatrist []

Telephone no. [] Date of last visit or consult with psychiatrist []

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.*

[Empty text box for describing behavioral health services]

Section I. Please complete for bupropion hydrochloride extended-release 450 mg tablet, citalopram capsule, desvenlafaxine extended-release, duloxetine 40 mg capsule, escitalopram capsule, fluoxetine 60 mg tablet, fluoxetine 90 mg delayed-release capsule, fluvoxamine extended-release, imipramine pamoate, sertraline capsule, trazodone 300 mg tablet, venlafaxine besylate extended-release tablet, and venlafaxine hydrochloride extended-release tablet requests.

Please attach medical records documenting an inadequate response (defined as at least four weeks of therapy) or adverse reaction to the respective formulation of the agent requested at an equivalent dose that is available without prior authorization.

Section II. Please complete for amoxapine, Auvelity, clomipramine, desipramine, Exxua, Fetzima, Marplan, protriptyline, trimipramine, Trintellix, and vilazodone requests.

Please describe antidepressant trials and outcomes.*

Drug name [] Dates/duration of use [] Dose and frequency []

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

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

[Empty text box for describing adverse reaction]

Drug name [] Dates/duration of use [] Dose and frequency []

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

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

[Empty text box for describing adverse reaction]

Drug name [] Dates/duration of use [] Dose and frequency []

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

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

[Empty text box for describing adverse reaction]

Section III. Please complete for Emsam requests.

1. Has the member had a trial with one SSRI and one non-SSRI antidepressant?

Yes. Please list the drug name, dose and frequency, dates/duration of trials, and outcomes below.*

Drug name Dose and frequency 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, or other.

Drug name Dose and frequency 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, or other.

No. Please explain why not.

2. Is there a medical necessity for the transdermal formulation? Yes No

If yes, please explain.

Section IV. Please complete for Drizalma requests.

Please document medical necessity for the requested formulation instead of the solid oral formulation.

Section V. Please complete for mirtazapine orally disintegrating tablet requests.

Is there a medical necessity for the specific dosage formulation?

Yes. Please explain.

No. Has the member tried mirtazapine tablets?

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

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

Section VI. Please complete for Raldesy requests.

1. Does the member have a G-tube/J-tube? Yes No

If no, has the member had a trial with crushed trazodone tablets?

Yes. Please list the dose and frequency, dates/duration of trials, and outcomes below.*

Dose and frequency 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, or other.

No. Please describe why crushed trazodone tablets is not appropriate for this member.

2. Please describe medical necessity for use of the requested formulation.

3. Has the member had a trial with citalopram solution, escitalopram solution, fluoxetine solution, paroxetine solution, or sertraline solution?

Yes. Please list the drug name, dose and frequency, dates/duration of trials, and outcomes below.*

Drug name Dose and frequency 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, or other.

No. Please describe why citalopram solution, escitalopram solution, fluoxetine solution, paroxetine solution, and sertraline solution are not appropriate for this member.

Section VII. Please complete for olanzapine/fluoxetine requests.

Please describe the medical necessity for use of the combination product instead of the commercially available separate agents.

Section VIII. Please complete for Ketalar and Spravato requests.

For initial requests for Ketalar for MDD please complete questions 2 through 5. For recertification requests for Ketalar please complete question 7.

For initial requests for Spravato for MDD with acute suicidal ideation or behavior, please complete questions 1, 5, and 6. For initial requests for Spravato for MDD or treatment resistant depression (TRD), please complete questions 1 through 4. For recertification requests for Spravato for TRD, please complete questions 1 and 7.

1. For Spravato, please select the indication and requested dosing regimen.

MDD with acute suicidal ideation or behavior

84 mg twice weekly for four weeks

Other

Please explain requested dosing.

MDD or TRD (without acute suicidal ideation or behavior)

Weeks 1 to 4: 56 mg twice weekly 84 mg twice weekly

Weeks 5 to 8: 56 mg once weekly 84 mg once weekly

Weeks 9 to 52: 56 mg once weekly 56 mg once every other week

84 mg once weekly 84 mg once every other week

Greater than 52 weeks: 56 mg once weekly 56 mg once every other week

84 mg once weekly 84 mg once every other week

Other Week of therapy

Please explain requested dosing.

2. Please attach medical records documenting an inadequate response to monotherapy (defined as ≥ four weeks of therapy with a single agent) or adverse reaction to one SSRI and one non-SSRI antidepressant. If there is a contraindication to SSRI and non-SSRI antidepressants, attach medical records documenting the contraindication.

3. Please attach medical records documenting an inadequate response (defined as ≥ four weeks of therapy) or adverse reaction to one augmentation strategy (defined as overlap of an SSRI or SNRI in combination with one of the following: a second-generation antipsychotic, carbamazepine, lamotrigine, lithium, a second antidepressant from a different class, thyroid hormone, divalproex/valproate/valproic acid) following two failed monotherapy trials. If there is a contraindication to all antidepressant augmentation strategies, attach medical records documenting the contraindication.

4. For initial requests, please attach medical records documenting a current depression assessment using any validated depression rating scale (e.g., Montgomery-Asberg Depression Rating Scale [MADRS], Hamilton Depression Rating Scale [HAM-D], Patient Health Questionnaire Depression Scale [PHQ-9], Beck Depression Inventory [BDI]).
5. Will the requested agent be used in combination with an oral antidepressant? Yes No
6. Please attach medical records dated within the last four weeks documenting either current acute suicidal ideation or behavior related to depressive symptoms of MDD, or that the member was stabilized on Spravato during a psychiatric hospitalization.
7. For recertification requests, please provide current depression score and rating scale (e.g., MADRS, HAM-D, PHQ-9, BDI). Date

Section IX. Please complete for bupropion XL > 1 unit/day, desvenlafaxine succinate extended-release 25 mg, 50 mg tablet > 1 unit/day, or desvenlafaxine succinate extended-release 100 mg tablet > 4 units/day requests.

Has dose consolidation been attempted? Yes No. Please describe medical necessity for quantities above 1 unit/day.

Section X. Please complete for Zurzuvae requests.

1. Is the member \leq 12 months postpartum? Yes. Please document date of delivery. No
2. Is the member currently pregnant? Yes No
3. Has the member had a trial with one of the following: bupropion, citalopram, duloxetine, escitalopram, fluoxetine, mirtazapine, sertraline, venlafaxine?
 Yes. Please list the drug name, dose and frequency, dates/duration of trials, and outcomes below.*
Drug name Dose and frequency 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, or other.
- No. Please explain why not.
4. Does the member have a requirement for rapid symptom reduction? Yes No
5. Requests for 30 mg capsule, does the member have severe hepatic impairment (Child-Pugh Class C) or moderate to severe renal impairment (eGFR < 60 mL/min/1.73m²)?
 Yes. Please describe.
 No
6. For recertification requests, please provide the last day of treatment with the requested agent and the total number of treatments including the current request.
Last day of treatment with requested agent
Total number of treatments including the current request

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

Section XI. Antidepressant Polypharmacy for members ≥ 18 years of age. Please complete information for medications requested and select the reason for polypharmacy with antidepressants (two or more SSRI, SNRI, or Serotonin Modulator antidepressants for ≥ 60 days within a 90-day period).

1. Antidepressant name/dose/frequency Indication
2. Antidepressant name/dose/frequency Indication
3. Antidepressant name/dose/frequency Indication

Is member under the care of a psychiatrist?

Yes. Please attach specialist consult details (if the prescriber submitting the request is not a specialist). No
For mid-level practitioners (e.g., nurse practitioners, physician assistants), please provide the name and specialty of the collaborating physician, if applicable.

- Member was recently discharged from an inpatient setting on requested medications and is currently stable.
 Member experienced an inadequate response or adverse reaction to two monotherapy trials with antidepressants.

Drug name 1 Dates/Duration of use (if available)

Drug name 2 Dates/Duration of use (if available)

Member is transitioning from one antidepressant to the other.

Other, please explain.

Section XII. 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

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: 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. Antidepressant Polypharmacy. Complete this section for all members < 18 years of age, if request will result in prescription of two or more antidepressants ≥ 60 days within a 90-day period.

Please document if monotherapy trials (include drug name, dates/duration of use, and outcome) with antidepressants were tried before prescribing polypharmacy with two or more antidepressants 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 an antidepressant 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. Antidepressant Request for Members < six years of age.

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

Please document clinical rationale for use of an antidepressant 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.)