



# 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.

|  |
|--|
| <b>MassHealth Fee-For-Service (FFS) Plan, Primary Care Clinician (PCC) Plan, Primary Care Accountable Care Organization (PCACO) Plan, and Children's Medical Security Plan</b>   |
| <input type="checkbox"/> <b>MassHealth Drug Utilization Review Program</b><br>Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318  |
| <b>MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)</b>  |
| <input type="checkbox"/> <b>Fallon Health</b><br>Online Prior Authorization: <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a><br>Online Prior Authorization: <a href="http://providerportal.surescripts.net/ProviderPortal/optum">providerportal.surescripts.net/ProviderPortal/optum</a><br>Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033   |
| <input type="checkbox"/> <b>Health New England</b><br>Online Prior Authorization: <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a><br>Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545  |
| <input type="checkbox"/> <b>Mass General Brigham Health Plan</b><br>Online Prior Authorization (Pharmacy Benefit Reviews): <a href="http://go.covermymeds.com/OptumRx">go.covermymeds.com/OptumRx</a><br>Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555<br>Online Prior Authorization (Medical Specialty Reviews): <a href="http://provider.massgeneralbrighamhealthplan.org">provider.massgeneralbrighamhealthplan.org</a><br>Medical Specialty Reviews: Fax: (888) 656-6671 - Tel: (833) 895-2611 |
| <input type="checkbox"/> <b>Tufts Health Plan</b><br>Online Prior Authorization: <a href="http://point32health.promptpa.com">point32health.promptpa.com</a><br>Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985   |
| <input type="checkbox"/> <b>WellSense Health Plan</b><br>Online Prior Authorization: <a href="http://wellsense.org/providers/ma/pharmacy/prior-authorizations">wellsense.org/providers/ma/pharmacy/prior-authorizations</a><br>Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822   |

# Benzodiazepines and Other Antianxiety Agents

## 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 benzodiazepines or other antianxiety agents 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](http://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"/> alprazolam extended-release (ER) >2 units/day               | <input type="checkbox"/> flurazepam                                 |
| <input type="checkbox"/> alprazolam orally disintegrating tablet (ODT)               | <input type="checkbox"/> lorazepam solution ≥ 13 years of age       |
| <input type="checkbox"/> alprazolam solution ≥ 13 years of age                       | <input type="checkbox"/> Loreev XR (lorazepam extended-release)     |
| <input type="checkbox"/> amitriptyline/chlordiazepoxide                              | <input type="checkbox"/> meprobamate                                |
| <input type="checkbox"/> buspirone capsule   | <input type="checkbox"/> oxazepam                                   |
| <input type="checkbox"/> Byfavo (remimazolam) <sup>MB</sup>                          | <input type="checkbox"/> quazepam                                   |
| <input type="checkbox"/> clonazepam ODT 0.125 mg, 0.25 mg, 0.5 mg, 1 mg >3 units/day | <input type="checkbox"/> temazepam 7.5 mg, 15 mg, 30 mg >1 unit/day |
| <input type="checkbox"/> clonazepam ODT 2 mg >2 units/day                            | <input type="checkbox"/> temazepam 22.5 mg                          |
| <input type="checkbox"/> clorazepate   | <input type="checkbox"/> triazolam >1 unit/day                      |
| <input type="checkbox"/> diazepam 25 mg/5 mL solution                                | <input type="checkbox"/> Other* <input type="text"/>                |
| <input type="checkbox"/> estazolam >1 unit/day                                       |   |

*\*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).*

<sup>MB</sup> *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**  **Quantity requested per month**

**Indication(s) or ICD-10 code(s), if applicable**

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

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

Drug NDC (if known) or service code

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.*

**Section I. Concomitant Opioid and Benzodiazepine Polypharmacy. Please complete information for medications requested and clinical rationale for polypharmacy with opioids and benzodiazepines [one or more benzodiazepine(s), excluding clobazam, nasal and rectal diazepam, nasal midazolam, and injectable formulations, and one or more opioid(s) for ≥15 days within a 45-day period].**

Please document the indication or ICD-10 code(s), if applicable, for the agents requested.

1. Benzodiazepine

|                     |                      |            |                      |
|---------------------|----------------------|------------|----------------------|
| Name/dose/frequency | <input type="text"/> | Indication | <input type="text"/> |
| Name/dose/frequency | <input type="text"/> | Indication | <input type="text"/> |
| Name/dose/frequency | <input type="text"/> | Indication | <input type="text"/> |

2. Opioid

|                     |                      |            |                      |
|---------------------|----------------------|------------|----------------------|
| Name/dose/frequency | <input type="text"/> | Indication | <input type="text"/> |
| Name/dose/frequency | <input type="text"/> | Indication | <input type="text"/> |
| Name/dose/frequency | <input type="text"/> | Indication | <input type="text"/> |

Please document clinical rationale for concomitant use of opioids and benzodiazepines for this member.

  


Please describe the ongoing treatment plan for continued use.

  


For the diagnosis of a seizure disorder, is the member currently receiving a non-benzodiazepine anticonvulsant?

Yes. Drug name  Dates  Outcome

No. Please explain why not.

For the diagnosis of a sleep disorder, has the member had trials with three non-benzodiazepine sleep medications?

Yes. Drug name  Dates  Outcome

Drug name  Dates  Outcome

Drug name  Dates  Outcome

No. Please explain why not.

For the diagnosis of a psychiatric disorder (e.g., generalized anxiety disorder, panic disorder, post-traumatic stress disorder, etc.), has the member had trials with three antidepressants?

Yes. Drug name  Dates  Outcome

Drug name  Dates  Outcome

Drug name  Dates  Outcome

No. Please explain why not.

For the diagnosis of a musculoskeletal disorder, has the member had trials with three skeletal muscle relaxants?

|   |                      |                      |                      |                      |                      |
|---|----------------------|----------------------|----------------------|----------------------|----------------------|
| <input type="checkbox"/> Yes. Drug name | <input type="text"/> | Dates                | <input type="text"/> | Outcome              | <input type="text"/> |
|   | Drug name            | <input type="text"/> | Dates                | <input type="text"/> | Outcome              |
|   | Drug name            | <input type="text"/> | Dates                | <input type="text"/> | Outcome              |

No. Please explain why not.

Has consideration been given for possible taper of benzodiazepine or opioid?

Yes. Please describe plan for taper and plan to reevaluate in the future.

No. Please describe why taper is not possible at this time and plan to reevaluate in the future.

Has the member been hospitalized for a psychiatric condition (non-overdose related) 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 risk of harm to self or others?

Yes. Please provide details.

No

Has the member been offered and/or given a prescription for naloxone treatment?

Yes  No. Please provide details.

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

**Section II. Benzodiazepine Polypharmacy for members ≥ 18 years of age. Please complete information for medications requested and clinical rationale for polypharmacy with benzodiazepines (two or more benzodiazepines, excluding clobazam, nasal and rectal diazepam, nasal midazolam, and injectable formulations for ≥ 60 days within a 90-day period).**

Please document complete treatment plan (include all agents requested from the same medication class and indication(s) or ICD-10 code(s), if applicable, for each medication(s)).

|                                       |                      |            |                      |
|---------------------------------------|----------------------|------------|----------------------|
| 1. Benzodiazepine name/dose/frequency | <input type="text"/> | Indication | <input type="text"/> |
| 2. Benzodiazepine name/dose/frequency | <input type="text"/> | Indication | <input type="text"/> |
| 3. Benzodiazepine name/dose/frequency | <input type="text"/> | Indication | <input type="text"/> |

Please document clinical rationale for polypharmacy within the same medication class for this member (include prior therapy trials, severity of symptoms, etc.)

Has consideration been given for consolidation to a single benzodiazepine agent?

Yes. Please describe plan for cross-titration or taper.   No

Please describe why dose consolidation is not possible at this time and plan to reevaluate in the future.

[Text input box]

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. [Text input box]
- No

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

- Yes. Please provide details. [Text input box]
- No

**Section III. Please complete for requests for alprazolam ODT, alprazolam oral solution for members ≥ 13 years of age, diazepam 25 mg/5 mL oral solution, and lorazepam oral solution for members ≥ 13 years of age.**

Please describe the medical necessity for use of the requested dosage formulation. Include prior trials of agents and describe dose consolidation as appropriate.

[Text input box]

**Section IV. Please complete for requests for > 2 units/day of alprazolam ER and clonazepam ODT 2 mg, and > 3 units/day of clonazepam ODT 0.125 mg, 0.25 mg, 0.5 mg, and 1 mg.**

1. Can the dose be consolidated within quantity limits?  Yes  No
2. Please describe clinical rationale for dosing higher than the FDA approved limits.

[Text input box]

3. Please attach medical records documenting titration of medication up to current dose.
4. For clonazepam ODT, please indicate prescriber specialty below.

- Psychiatry  Neurology  Other [Text input box]

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

[Text input box]

Name(s) of the specialist(s) [Text input box] Date(s) of last visit or consult [Text input box]

Contact information [Text input box]

**Section V. Please complete for requests for flurazepam, quazepam and temazepam 22.5 mg.**

For requests for flurazepam, quazepam and ≤1 unit/day of temazepam 22.5 mg, please complete question 1. For requests for 2 units/day of temazepam 22.5 mg, please complete all of the following questions.

1. Has the member had a trial of estazolam, temazepam 7.5 mg, 15 mg, or 30 mg, and triazolam?

- Yes

|           |                  |       |                  |         |                  |
|-----------|------------------|-------|------------------|---------|------------------|
| Drug name | [Text input box] | Dates | [Text input box] | Outcome | [Text input box] |
| Drug name | [Text input box] | Dates | [Text input box] | Outcome | [Text input box] |
| Drug name | [Text input box] | Dates | [Text input box] | Outcome | [Text input box] |
| Drug name | [Text input box] | Dates | [Text input box] | Outcome | [Text input box] |

- No. Please explain why not. [Text input box]

2. Has the member had an inadequate response to a dose of 30 mg/day?  Yes  No
3. Please attach medical records documenting titration of medication up to current dose.
4. Please describe clinical rationale for dosing higher than the FDA approved limits.

**Section VI. Please complete for requests for > 1 unit/day of estazolam, flurazepam, temazepam (7.5 mg, 15 mg, 22.5 mg, and 30 mg), triazolam, and quazepam.**

1. Can the dose be consolidated within quantity limits?  Yes  No
2. Was a higher dose effective in alleviating symptoms?  Yes  No
3. Has the member had an inadequate response to 1 unit/day?  Yes  No
4. For triazolam 0.25 mg, has the member had an inadequate response to a dose of 0.25 mg/day?  
 Yes  No
5. For requests exceeding the FDA-approved maximum dose, has the member experienced an inadequate response or adverse reaction to other alternatives for sleep?  
 Yes

|   |   |   |
|---|---|---|
| Drug name <input style="width: 100%;" type="text"/> | Dates <input style="width: 100%;" type="text"/> | Outcome <input style="width: 100%;" type="text"/> |
| Drug name <input style="width: 100%;" type="text"/> | Dates <input style="width: 100%;" type="text"/> | Outcome <input style="width: 100%;" type="text"/> |
| Drug name <input style="width: 100%;" type="text"/> | Dates <input style="width: 100%;" type="text"/> | Outcome <input style="width: 100%;" type="text"/> |
| Drug name <input style="width: 100%;" type="text"/> | Dates <input style="width: 100%;" type="text"/> | Outcome <input style="width: 100%;" type="text"/> |

No. Please explain why not.

**Section VII. Please complete for requests for meprobamate.**

1. Has the member had a trial with at least two benzodiazepines?  
 Yes

|   |   |   |
|---|---|---|
| Drug name <input style="width: 100%;" type="text"/> | Dates <input style="width: 100%;" type="text"/> | Outcome <input style="width: 100%;" type="text"/> |
| Drug name <input style="width: 100%;" type="text"/> | Dates <input style="width: 100%;" type="text"/> | Outcome <input style="width: 100%;" type="text"/> |

No. Please explain why not.

2. If requesting recertification, please provide clinical rationale for continued therapy and details of trials with alternatives (e.g., SSRIs, SNRIs, TCAs, buspirone).

**Section VIII. Please complete for requests for Byfavo.**

1. Will Byfavo be used for induction and maintenance of procedural sedation?

Yes. Please provide procedure date.

No.

2. Please provide clinical rationale for use instead of intravenous midazolam.

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**Section IX. Please complete for requests for amitriptyline/chlordiazepoxide.**

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

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**Section X. Please complete for requests for clorazepate and oxazepam.**

Has the member had a trial with two of the following benzodiazepines: alprazolam, chlordiazepoxide, clonazepam, diazepam, or lorazepam?

Yes. Please list the drug names, dates/duration of use, and outcomes below.\*

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, 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, or other.

No. Please explain why not.

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

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**Section XI. Please complete for requests for Loreev XR.**

Please attach medical records documenting stability with lorazepam tablets in three evenly divided daily doses and trials with two intermediate/long- or long-acting benzodiazepines. If all other long-acting benzodiazepines are contraindicated, please describe. For requests for > 1 unit/day, describe medical necessity for exceeding the quantity limit.

  

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**Section XII. Please complete for requests for buspirone capsule.**

Please attach medical records documenting inadequate response or adverse reaction to buspirone tablet at an equivalent dose to the requested dose.

1. Has the member had a trial with at least two SSRIs/SNRIs?

Yes

Drug name  Dates  Outcome

Drug name  Dates  Outcome

No. Please explain why not.

2. For requests for 7.5 mg (>2 units/day), 10 mg (>3 units/day), and 15 mg (>4 units/day), describe medical necessity for exceeding the quantity limit.

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**Section XIII. 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

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**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.

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**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)

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 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.

- Department of Children and Families (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, 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. Benzodiazepine Polypharmacy. Complete this section for all members < 18 years of age, if request will result in prescription of two or more benzodiazepine agents for ≥ 60 days within a 90-day period (excluding hypnotic benzodiazepine agents, clobazam, nasal and rectal diazepam, nasal midazolam, and injectable formulations).**

Please document if monotherapy trials (include drug name, dates/duration of use, and outcome) with benzodiazepine agents were tried before prescribing polypharmacy with two or more benzodiazepine agents in 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.

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

**Section III. Benzodiazepine Request for Members < six years of age.**

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

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

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

[Empty text box]

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.\*

[Empty text box]

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

[Empty text box]

[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.

[Empty text box]

[Empty text box]

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"/> |
| 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"/> |
|----------------------|------|----------------------|

(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.)