Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

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**.

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested (Check one or all that apply.)

- ☐ Aptiom (eslicarbazepine)
- ☐ Briviact (brivaracetam solution, tablet)
- ☐ Diacomit (stiripentol)
- ☐ diazepam rectal gel > 5 kits (10 syringes)/month
- ☐ Elepsia XR (levetiracetam extended-release)
- ☐ Epidiolex (cannabidiol)
- ☐ Eprontia (topiramate solution)
- ☐ everolimus 2.5 mg, 5 mg, 7.5 mg, 10 mg
- ☐ everolimus tablets for oral suspension
- ☐ Fintepla (fenfluramine)
- ☐ Fycompa (perampanel)
- ☐ gabapentin >3600 mg/day
- ☐ lacosamide solution, tablet
- ☐ Lamictal XR starter kit, lamotrigine extended-release
- ☐ lamotrigine orally disintegrating tablet (ODT), ODT starter kit
- ☐ lamotrigine tablet starter kit
- ☐ Nayzilam (midazolam nasal spray) >10 units/month
- ☐ Oxtellar XR (oxcarbazepine extended-release)
- ☐ pregabalin
- ☐ rufinamide
- ☐ Spritam (levetiracetam tablet for oral suspension)
- ☐ Sympazan (clobazam film)
- ☐ tiagabine
- ☐ Trokendi XR (topiramate extended-release capsule)
- ☐ Valtoco (diazepam nasal spray) >10 units/month
- ☐ vigabatrin
- ☐ Xcopri (cenobamate)
- ☐ Other* _____

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.)

- ☐ Bipolar disorder
- ☐ Diabetic peripheral neuropathy
- ☐ Dravet syndrome
- ☐ Epilepsy or seizure disorder
  Type _____
- ☐ Epilepsy associated with tuberous sclerosis complex
- ☐ Fibromyalgia
- ☐ Infantile spasms
- ☐ Lennox-Gastaut syndrome
- ☐ Migraine prophylaxis
- ☐ Pain associated with trigeminal neuralgia
- ☐ Postherpetic neuralgia
- ☐ Other _____

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

_____

_____

Please indicate prescriber specialty below.

☐ Neurology ☐ Psychiatry ☐ Other _____

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.

_____

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.

_____

Section I. Please complete for all requests as needed.

Please provide the following information regarding previous trials.*

1. Drug _____ Dates of Use _____ Outcome _____
2. Drug _____ Dates of Use _____ Outcome _____
3. Drug _____ Dates of Use _____ Outcome _____

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

Section II. Please also complete for requests for Elepsia XR, Eprontia, Lamictal XR starter kit, lamotrigine extended-release, lamotrigine tablet starter kit, Oxtellar XR, Spritam, and Trokendi XR.

For Elepsia XR, Eprontia, Lamictal XR starter kit, lamotrigine extended-release, lamotrigine tablet starter kit and diagnoses other than epilepsy or seizure disorder, only question 1 is required.

1. Please provide medical necessity for the use of the requested formulation instead of the respective formulation(s) that is available without prior authorization.

   _____

2. Has the member been stabilized on the requested agent (any form)? ☐ Yes ☐ No

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

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

_____

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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. For requests for Epidiolex, please attach medical records supporting the diagnosis.

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), Nayzilam (> 10 units/month), and Valtoco (> 10 units/month).

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. Concomitant gabapentin and pregabalin. 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.

_____

**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.

_____

_____

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.

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.

_____

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)

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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*

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 complete treatment plan (include all mood stabilizing agents).

1. Mood stabilizer name/dose/frequency _____ Indication _____
2. Mood stabilizer name/dose/frequency _____ Indication _____
3. Mood stabilizer name/dose/frequency _____ Indication _____
4. Mood stabilizer name/dose/frequency _____ Indication _____
5. Other(s) _____

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.

_____

_____

_____

**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 complete treatment plan (include all mood stabilizer agents with dose/frequency/duration and indication(s) for the requested medication(s)).

_____

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.

_____

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

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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. For a complete list of all behavioral health medications, please refer to the MassHealth Pediatric Behavioral Health Medication Initiative (agents considered to be used only for seizure diagnoses are not included).

Please document complete treatment plan (include all behavioral health agents and indication(s) for each medication(s)).

1. Medication name/dose/frequency _____ Indication _____
2. Medication name/dose/frequency _____ Indication _____
3. Medication name/dose/frequency _____ Indication _____
4. Medication name/dose/frequency _____ Indication _____
5. Medication name/dose/frequency _____ Indication _____
6. Medication name/dose/frequency _____ Indication _____
7. Other(s) _____

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

_____

_____

_____

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

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my 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.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____