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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, Children's Medical Security Plan, and Health Safety Net 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.covermymeds.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.covermymeds.com/OptumRx Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
☐ **Mass General Brigham Health Plan** Online Prior Authorization (Non-Specialty Drugs): go.covermymeds.com/OptumRx Online Prior Authorization (Specialty/Medical Drugs): provider.massgeneralbrighamhealthplan.org Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555
☐ **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

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Anticonvulsant
Prior Authorization Request

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

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

Medication information

Medication requested (Check one or all that apply.)

- ☐ 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
- ☐ 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
- ☐ topiramate extended-release capsule [Trokendi XR]
- ☐ Valtoco (diazepam nasal spray) >10 units/month
- ☐ vigabatrin
- ☐ Xcopri (cenobamate)
- ☐ Zonisade (zonisamide suspension)
- ☐ Ztalmy (ganaxolone)
- ☐ 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 or include ICD-10 code, if applicable.)

- ☐ Bipolar disorder
- ☐ Cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) (provide documentation of genetic testing)
- ☐ 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, if applicable.

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
4. 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, topiramate extended-release capsule [Trokendi XR], and Zonisade.

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

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.

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.

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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/30 days), and Valtoco (> 10 units/30 days).

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

   _____

   _____

Section VIII. 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.

_____

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Section IX. 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

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

MassHealth Pediatric Behavioral Health Medication Initiative

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

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

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

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

☐ Yes. Please document dates of hospitalization within the past three months.
☐ No

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

☐ Yes. Please provide details. ☐ No

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

☐ Yes ☐ No. Please explain.

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

Please indicate prescriber specialty below.

☐ Psychiatry ☐ Neurology ☐ Other

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

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

Contact information

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

Please document member custody status.

☐ Parent/Guardian ☐ Department of Children and Families (DCF)

Please document member placement status.

☐ Home with Parent/Guardian ☐ Foster Care ☐ Residential Treatment Facility

☐ Uncertain ☐ Other

Please document agency involvement.

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

☐ Department of Youth Services (DYS)

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

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

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

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

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

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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) or ICD-10 code(s), if applicable, 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.

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

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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

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

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Prior Authorization Request Prescriber and Provider Information

Prescriber Information

Last name* First name* MI

NPI* Individual MH Provider ID

DEA No. Office Contact Name

Address City State Zip

Email address

Telephone No.* Fax No.*

** Required*

Please also complete for professionally administered medications, if applicable.

Start date End date

Servicing prescriber/facility name ☐ Same as prescribing provider

Servicing provider/facility address

Servicing provider NPI/tax ID No.

Name of billing provider

Billing provider NPI No.

Is this a request for recertification? ☐ Yes ☐ No

CPT code No. of visits J code No. of units

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 _____

Printed name of prescribing provider Date

(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.)