Print Clear

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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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

- ☐ Aplenzin (bupropion hydrobromide extended-release) > 1 unit/day
- ☐ Auvelity (dextromethorphan/bupropion)
- ☐ bupropion XL > 1 unit/day
- ☐ bupropion hydrochloride extended-release 450 mg tablet
- ☐ citalopram capsule
- ☐ clomipramine
- ☐ desipramine
- ☐ desvenlafaxine extended-release
- ☐ desvenlafaxine succinate extended-release > 1 unit/day
- ☐ Drizalma (duloxetine sprinkle capsule)
- ☐ duloxetine 40 mg capsule
- ☐ Emsam (selegiline)
- ☐ Fetzima (levomilnacipran)
- ☐ fluoxetine 60 mg tablet
- ☐ fluoxetine 90 mg delayed-release capsule
- ☐ fluvoxamine extended-release
- ☐ imipramine pamoate tablet
- ☐ Ketalar (ketamine injection)[MB]
- ☐ Marplan (isocarboxazid)
- ☐ mirtazapine orally disintegrating tablet
- ☐ olanzapine/fluoxetine
- ☐ paroxetine controlled-release
- ☐ Pexeva (paroxetine mesylate tablet)
- ☐ protriptyline
- ☐ sertraline capsule
- ☐ Spravato (esketamine)
- ☐ trazodone 300 mg tablet
- ☐ trimipramine
- ☐ Trintellix (vortioxetine)
- ☐ venlafaxine besylate extended-release tablet
- ☐ venlafaxine hydrochloride extended-release tablet
- ☐ vilazodone
- ☐ Zulresso (brexanolone)[MB]
- ☐ Zurzuvae (zuranolone)
- ☐ Other*

** 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, prior authorization does not apply through the hospital outpatient and inpatient settings. Please refer to 130 CMR 433.408 for prior authorization 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 prior authorization 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.)

- ☐ Major depressive disorder
- ☐ Obsessive-compulsive disorder
- ☐ Premenstrual dysphoric disorder
- ☐ Panic disorder
- ☐ Postpartum depression
- ☐ Other (describe)

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

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.

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

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. For Pexeva, in addition attach medical records of paroxetine controlled-release trial.

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

Please describe applicable antidepressant trials and outcomes (attach a letter with additional information regarding trials as applicable).

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.

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.

Section III. Please complete for requests for Emsam.

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

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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 requests for Drizalma

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

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

Is there a medical necessity for the specific dosage formulation?

☐ Yes. Please explain.

☐ No. Please attach medical records documenting an inadequate response (defined as at least four weeks of therapy) or adverse reaction to mirtazapine tablet.

Section VI. Please complete for requests for olanzapine/fluoxetine.

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

Section VII. Please complete for requests for Ketalar and Spravato.

For requests for Ketalar and Spravato for treatment resistant depression, please complete questions 1, 2, and 4. Initial requests for Spravato for major depressive disorder with acute suicidal ideation or behavior, please complete questions 3 and 4. Subsequent requests for Spravato for major depressive disorder with acute suicidal ideation or behavior should complete the questions for treatment resistant depression.

1. Please attach medical records documenting a trial with one SSRI and one non-SSRI antidepressant.
2. Please attach medical records documenting a trial with one of the following antidepressant augmentation strategies: second-generation antipsychotic, lithium, a second antidepressant from a different class, thyroid hormone. If there is a contraindication to all antidepressant augmentation strategies, attach medical records documenting the contraindication.
3. Please attach medical records documenting either current acute suicidal ideation or behavior related to depressive symptoms of major depressive disorder, or that the member was stabilized on esketamine during a psychiatric hospitalization.
4. Will the requested agent be used in combination with an oral antidepressant? ☐ Yes ☐ No

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Section VIII. Please complete for requests for Aplenzin > 1 unit/day, bupropion XL > 1 unit/day, or desvenlafaxine succinate extended-release > 1 unit/day.

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

Section IX. Please complete for requests for Zulresso.

1. Is the member pregnant? ☐ Yes ☐ No. Please document date of delivery.
2. Please document date of onset of major depressive episode(s).
3. Member's current weight Date

Section X. Please complete for requests for Zurzuvae.

1. Is the member ≤ 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. For 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/1.73m^2)?
   ☐ 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

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

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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

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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.

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: ☐ 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)

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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. 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 complete treatment plan (include all antidepressant agents).

1. Antidepressant name/dose/frequency Indication
2. Antidepressant name/dose/frequency Indication
3. Antidepressant name/dose/frequency Indication
4. Other(s)

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.

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

Section III. Antidepressant Request for Members < six years of age.

Please document complete treatment plan (include all antidepressant 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 an antidepressant 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.

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 _____
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._

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.)