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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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**. 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.)

- ☐ alprazolam extended-release (ER) >2 units/day
- ☐ alprazolam orally disintegrating tablet (ODT)
- ☐ amitriptyline/chlordiazepoxide
- ☐ Byfavo (remimazolam) MB
- ☐ clonazepam ODT 0.125 mg, 0.25 mg, 0.5 mg, 1 mg >3 units/day
- ☐ clonazepam ODT 2 mg >2 units/day
- ☐ clorazepate
- ☐ estazolam >1 unit/day
- ☐ flurazepam >1 unit/day
- ☐ Loreev XR (lorazepam extended-release)
- ☐ meprobamate
- ☐ oxazepam
- ☐ quazepam
- ☐ temazepam 7.5 mg, 15 mg, 30 mg >1 unit/day
- ☐ temazepam 22.5 mg
- ☐ triazolam >1 unit/day
- ☐ 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 _____ **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.

_____

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 _____ Indication _____

Name/dose/frequency _____ Indication _____

Name/dose/frequency _____ Indication _____

2. Opioid

Name/dose/frequency _____ Indication _____

Name/dose/frequency _____ Indication _____

Name/dose/frequency _____ Indication _____

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. _____

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

☐ Yes. Drug name Dates Outcome

Drug name Dates Outcome

Drug name Dates 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 Indication
2. Benzodiazepine name/dose/frequency Indication
3. Benzodiazepine name/dose/frequency Indication

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

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

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

Section III. Please complete for requests for alprazolam ODT.

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

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.
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

   ☐ 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

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

1. Can the dose be consolidated within quantity limits? ☐ Yes ☐ No
2. Was a higher dose was 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	Dates	Outcome
Drug name	Dates	Outcome
Drug name	Dates	Outcome
Drug name	Dates	Outcome

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☐ No. Please explain why not.

Section VI. Please complete for requests for quazepam and temazepam 22.5 mg.

For requests for 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. Please attach medical records documenting an inadequate response or adverse reaction to all hypnotic benzodiazepines (e.g., estazolam, flurazepam, temazepam 7.5 mg, 15 mg, or 30 mg, triazolam). Please describe dose consolidation.
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 VII. Please complete for requests for meprobamate.

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

   Drug name Dates Outcome

   Drug name Dates Outcome

   ☐ 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.

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.

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

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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.*

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.

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 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)

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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, 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. 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 complete treatment plan (include all benzodiazepine agents and indication(s) or ICD-10 code(s), if applicable, for each medication(s)).

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

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. *

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 complete treatment plan (include all benzodiazepine agents with dose/frequency/duration and indication(s) or ICD-10 code, if applicable) for the requested medication(s).

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.*

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Please document clinical rationale for the use of a benzodiazepine agent in 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.

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.)