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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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Cerebral Stimulant and ADHD Drugs
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 ADHD medications 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 all that apply. Where applicable, the brand name is provided in brackets for reference.)

Long-Acting Cerebral Stimulants

- ☐ Adzenys XR-ODT (amphetamine extended-release orally disintegrating tablet)
- ☐ amphetamine extended-release 1.25 mg/mL oral suspension
- ☐ amphetamine salts extended-release [Adderall XR] > 2 units/day
- ☐ amphetamine salts extended-release [Mydayis]
- ☐ Azstarys (serdexmethylphenidate/ dexmethylphenidate)
- ☐ Cotempla XR-ODT (methylphenidate extended-release orally disintegrating tablet)
- ☐ dexmethylphenidate extended-release [Focalin XR] > 2 units/day
- ☐ Dyanavel XR (amphetamine extended-release 2.5 mg/mL oral suspension)
- ☐ Dyanavel XR (amphetamine extended-release chewable tablet)
- ☐ Jornay PM (methylphenidate extended-release)
- ☐ lisdexamfetamine capsule > 2 units/day
- ☐ lisdexamfetamine chewable tablet
- ☐ methylphenidate extended-release [Aptensio XR]
- ☐ methylphenidate extended-release [Concerta] > 2 units/day
- ☐ methylphenidate extended-release 72 mg tablet
- ☐ methylphenidate extended-release, CD
- ☐ methylphenidate long-acting capsule [Ritalin LA]
- ☐ methylphenidate transdermal [Daytrana] > 1 unit/day
- ☐ Quillichew ER (methylphenidate extended-release chewable tablet)
- ☐ Quillivant XR (methylphenidate extended-release oral suspension)
- ☐ Relexxii (methylphenidate extended-release tablet)
- ☐ Xelstrym (dextroamphetamine transdermal)

Intermediate/Short-Acting Cerebral Stimulants

- ☐ amphetamine salts [Adderall] > 3 units/day
- ☐ amphetamine sulfate
- ☐ dexmethylphenidate [Focalin] > 3 units/day
- ☐ dextroamphetamine 5 mg, 10 mg, 15 mg capsule [Dexedrine Spansule] > 3 units/day
- ☐ dextroamphetamine 2.5 mg, 7.5 mg, 15 mg, 20 mg, 30 mg tablet
- ☐ dextroamphetamine 5 mg, 10 mg tablet > 3 units/day
- ☐ dextroamphetamine solution > 40 mL/day
- ☐ Evekeo ODT (amphetamine sulfate orally disintegrating tablet)
- ☐ methylphenidate [Ritalin] > 3 units/day
- ☐ methylphenidate chewable tablet > 3 units/day
- ☐ methylphenidate oral solution [Methylin oral solution] > 30 mL/day
- ☐ methylphenidate sustained-release tablet > 3 units/day

Non-Stimulant Medications

- ☐ clonidine extended-release 0.1 mg tablet > 4 units/day
- ☐ Qelbree (viloxazine)

Other Medication

- ☐ 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).*

Dose, frequency, and duration of requested drug _____

Indication (Check all that apply or include ICD-10 code, if applicable.)

☐ Attention Deficit Hyperactivity Disorder (ADHD) ☐ Narcolepsy ☐ Other

Quantity requested per month **Total quantity of all stimulants combined**

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 cerebral stimulant requests above quantity limits.

1. Has dose consolidation been attempted? ☐ Yes ☐ No. Please explain why not.
2. Is the member under the care of a psychiatrist or behavioral specialist? ☐ Yes ☐ No
3. Please list all medications currently prescribed for this member for this condition.
4. Please describe your new treatment plan for managing this member's condition, including discontinuation of any medications because of the addition of medication requested.

Section II. Please complete for dextroamphetamine 2.5 mg, 7.5 mg, 15 mg, 20 mg, and 30 mg tablet requests.

Please provide medical necessity for requested strength instead of dextroamphetamine 5 mg and 10 mg tablets available without prior authorization.

Section III. Please complete for Azstarys, Cotempla XR-ODT, Jornay PM, methylphenidate extended-release [Aptensio XR] and long-acting capsule [Ritalin LA], methylphenidate extended-release CD, Quillichew ER, and Quillivant XR requests.

1. Please provide clinical rationale for use of the requested agent instead of Concerta (methylphenidate extended-release), or medical necessity for requested formulation instead of solid oral formulations (e.g., member utilizes a feeding tube, has a swallowing disorder or condition affecting ability to swallow, is < 13 years of age).
2. Please provide clinical rationale for use of the requested agent instead of methylphenidate transdermal and Focalin XR (dexmethylphenidate extended-release).

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Section IV. Please complete for Adzenys XR-ODT, amphetamine extended-release 1.25 mg/mL oral suspension, amphetamine salts extended-release [Mydayis], Dyanavel XR chewable tablet and oral suspension,lisdexamfetamine chewable tablet, and Xelstrym requests.

Please provide clinical rationale for use of the requested agent instead of Adderall XR (amphetamine salts extended-release) and lisdexamfetamine capsule.

Section V. Please complete for amphetamine sulfate requests.

Has the member tried an amphetamine immediate-release product that is available without prior authorization to treat this condition?

☐ Yes. Attach documentation of trials, including drug name, dose and frequency, dates of use, and outcomes.

☐ No. Explain why not.

Section VI. Please complete for methylphenidate extended-release 72 mg tablet and Relexxii requests.

Please provide clinical rationale for requested agent instead of Concerta (methylphenidate extended-release) (including use of two tablets to achieve the requested dose when applicable), methylphenidate transdermal, and Focalin XR (dexmethylphenidate extended-release).

Section VII. Please complete for Evekeo ODT requests.

Please provide medical necessity for requested formulation instead of solid oral formulations (e.g., member utilizes a feeding tube, has a swallowing disorder or condition affecting ability to swallow, is < 13 years of age).

Section VIII. Please complete for Qelbree requests.

Has the member tried atomoxetine to treat this condition?

☐ Yes. Please list the dates/duration of use, dose and frequency, and outcome below.

Dates 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.

☐ No. Explain why not.

Section IX. Please also complete for members ≥ 21 years of age (new to therapy).

1. For a diagnosis of ADHD, were symptoms present before 12 years of age according to the DSM-5 diagnostic criteria? ☐ Yes ☐ No ☐ Unknown

   Please provide detail regarding diagnosis if answered no or unknown.

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2. For all other diagnoses, please describe alternative first-line treatment options and non-pharmacologic interventions that have been implemented or trialed prior to cerebral stimulants.

Section X. 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

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. Cerebral Stimulant Polypharmacy. Complete this section for all members < 18 years of age, if request will result in prescription of two or more cerebral stimulants for ≥ 60 days within a 90-day period. Please note, immediate-release and extended-release formulations of the same chemical entity are counted as one.

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

1. Stimulant name/dose/frequency Indication

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2. Stimulant name/dose/frequency Indication

3. Stimulant name/dose/frequency Indication

4. Other(s)

Please document amphetamine and methylphenidate monotherapy trials (include drug name, dates/duration of use, and outcome) and rationale for polypharmacy with two or more cerebral stimulants 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. Alpha$_2$ Agonist or Cerebral Stimulant Request for Members < three years of age.

Please document the complete treatment plan (include all alpha$_2$ agonist and/or stimulant 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 alpha$_2$ agonist or cerebral stimulant for this member < three years of age.

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

Section IV. Atomoxetine or Qelbree Request for Members < six years of age.

Please document the complete treatment plan (include all stimulant and non-stimulant 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 atomoxetine for this member < six years of age.

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

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Section V. 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.)