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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Antipsychotic
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 antipsychotics 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(s) requested

- ☐ Abilify Asimtufii (aripiprazole extended-release injection)
- ☐ Abilify Maintena (aripiprazole extended-release injection)
- ☐ Abilify Mycite (aripiprazole tablet with sensor)
- ☐ aripiprazole orally disintegrating tablet (ODT)
- ☐ aripiprazole solution ≥ 18 years old and > 25 mL/day
- ☐ aripiprazole tablet > 2 units/day
- ☐ asenapine sublingual tablet
- ☐ Caplyta (lumateperone)
- ☐ clozapine ODT
- ☐ Fanapt (iloperidone)
- ☐ lurasidone
- ☐ Lybalvi (olanzapine/samidorphan)
- ☐ olanzapine ODT > quantity limits
- ☐ olanzapine tablet > 2 units/day
- ☐ paliperidone tablet
- ☐ perphenazine/amitriptyline
- ☐ Perseris (risperidone 90 mg, 120 mg extended-release subcutaneous injection) > 1 injection/ 28 days
- ☐ quetiapine > 3 units/day
- ☐ quetiapine extended-release > 2 units/day
- ☐ Rexulti (brexpiprazole)
- ☐ risperidone 3 mg, 4 mg ODT
- ☐ risperidone 0.25 mg, 0.5 mg, 1 mg, 2 mg, ODT > 2 units/day
- ☐ risperidone 12.5 mg, 25 mg, 37.5 mg, 50 mg extended-release intramuscular injection [Risperdal Consta] > 2 injections/28 days
- ☐ risperidone solution > 16 mL/day
- ☐ risperidone tablet > quantity limits
- ☐ Rykindo (risperidone 25 mg, 37.5 mg, 50 mg extended-release intramuscular injection)
- ☐ Secuado (asenapine transdermal)
- ☐ Uzedy (risperidone 50 mg, 75 mg, 100 mg, 125 mg extended-release subcutaneous injection) > 1 injection/28 days
- ☐ Uzedy (risperidone 150 mg, 200 mg, 250 mg extended-release subcutaneous injection) > 1 injection/56 days
- ☐ Versacloz (clozapine suspension)
- ☐ Vraylar (cariprazine)
- ☐ ziprasidone > 2 units/day
- ☐ Other

Dose and frequency of medication requested

For long-acting injectable agents, please indicate billing preference:

☐ Pharmacy ☐ Prescriber in-office ☐ Inpatient Psychiatry Unit

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

- ☐ Agitation associated with dementia due to Alzheimer's Disease
- ☐ Bipolar disorder
  - ☐ Bipolar depression
- ☐ Irritability associated with autistic disorder
- ☐ Major depressive disorder
- ☐ Psychosis, unspecified
- ☐ Schizophrenia
- ☐ Treatment-resistant depression
- ☐ Other

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. Monotherapy

Please select previous medication trial(s) as applicable.*

Please select previous medication trial(s) as applicable.*

**For aripiprazole ODT or solution for irritability associated with autistic disorder, a trial with risperidone alone is sufficient. For Abilify Asimtufii and Abilify Maintena requests, please document a trial of Aristada, or provide clinical rationale for use of the requested agent instead of Aristada. For Rykindo requests, please document a trial of risperidone extended-release intramuscular injection (generic Risperdal Consta), Perseris, and Uzedy, or provide clinical rationale for use of the requested agent instead of risperidone extended-release intramuscular injection (generic Risperdal Consta), Perseris, and Uzedy.*

☐ Trial(s) of second-generation (atypical) antipsychotics (Check all that apply.)

☐ aripiprazole ☐ clozapine ☐ olanzapine ☐ quetiapine ☐ risperidone ☐ ziprasidone ☐ Other

☐ Trial of other antipsychotics (Please specify below.)

Drug name 1 Drug name 2

☐ If requesting for major depressive disorder or treatment-resistant depression, please document trial(s) of antidepressants.

Drug name 1 Dates/Duration of use

Drug name 2 Dates/Duration of use

☐ If requesting Caplyta, lurasidone, or Vraylar for bipolar depression, in addition to trials with other second-generation (atypical) antipsychotics, please document trials with olanzapine monotherapy or combination therapy with fluoxetine and quetiapine immediate-release or extended-release, if applicable. †

Drug name 1 Dates/Duration of use

Drug name 2 Dates/Duration of use

†For lurasidone in members < 18 years of age, a diagnosis of bipolar depression alone is sufficient.

Please select reason(s) for medical necessity as applicable.

☐ Member is new to MassHealth and has been previously stabilized on requested medication.

☐ If request is for major depressive disorder or treatment-resistant depression, please note if the requested agent will be used as adjunctive therapy with current antidepressant treatment or provide clinical rationale why the member is not a candidate for antidepressant therapy.

☐ If requesting ODT, solution, or transdermal formulation, please also describe medical necessity for the specific dosage formulation.

☐ If requesting Abilify Mycite, please also describe the medical necessity for monitoring the member's ingestion of oral aripiprazole, and the member's training to use the Abilify Mycite system.

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☐ If requesting perphenazine/amitriptyline, please also describe the medical necessity for the use of the combination product instead of the commercially available separate agents.

☐ If requesting Lybalvi, please also complete the questions below.

1. Is the member being treated with an opioid? ☐ Yes ☐ No
2. Is the member being treated for acute opioid withdrawal? ☐ Yes ☐ No

☐ If requesting Caplyta 10.5 mg or 21 mg capsules, please also describe any drug-drug interactions resulting in the modified dosing regimen and document if the member has at least moderate or severe hepatic impairment (Child-Pugh Class B or C), if applicable.

☐ Other, please explain.

Section II. Antipsychotic Polypharmacy for members ≥ 18 years of age. Please complete information for medications requested and select the reason for polypharmacy with antipsychotics (two or more first-generation and/or second-generation antipsychotics for ≥ 60 days within a 90-day period).

1. Antipsychotic name/dose/frequency Indication
2. Antipsychotic name/dose/frequency Indication
3. Antipsychotic name/dose/frequency Indication

Is member under the care of a specialist (e.g., psychiatry, neurology, or developmental/behavioral health)?
☐ 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 antipsychotics.

Drug name 1 Dates/Duration of use (if available)
Drug name 2 Dates/Duration of use (if available)

☐ Member is transitioning from one antipsychotic to the other.
☐ Other, please explain.

Section III. Quantity Limits. Please complete information for medication requested and select the reason for exceeding established quantity limits.

Drug, dose, and frequency of requested antipsychotic
☐ Member is not a candidate for dose consolidation (e.g., risperidone 1 mg three times daily can be consolidated to risperidone 3 mg once daily, which is available without PA).

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☐ Other. Please describe medical necessity for exceeding quantity limits.

Section IV. 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. Antipsychotic Polypharmacy. Complete this section for all members < 18 years of age if request will result in prescription of two or more antipsychotics for ≥ 60 days within a 90-day period.

Please document complete treatment plan (include all antipsychotic agents [first-generation and/or second-generation]).

1. Antipsychotic name/dose/frequency Indication

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2. Antipsychotic name/dose/frequency _____ Indication _____

3. Antipsychotic name/dose/frequency _____ Indication _____

4. Other(s) _____

Please select the stage of treatment and clinical rationale for antipsychotic polypharmacy.

☐ **Acute stage** (initiation of antipsychotic treatment likely with subsequent dose adjustments to maximize response and minimize side effects)

☐ Member experienced an inadequate response or adverse reaction to two monotherapy trials with antipsychotics.

Drug name 1 _____ Dates/Duration of use _____

Drug name 2 _____ Dates/Duration of use _____

☐ Member is transitioning from one antipsychotic to the other.

☐ Other, please explain. _____

☐ **Maintenance stage** (response to antipsychotic treatment with goal of remission or recovery)

1. Is the regimen effective, therapy benefits outweigh risks, and appropriate monitoring is in place?
   ☐ Yes ☐ No
2. Has the member been on the requested regimen for ≥ 12 months?

☐ Yes. Please document clinical rationale for extended therapy.

☐ Previous efforts to reduce/simplify the antipsychotic regimen in the past 24 months resulted in symptom exacerbation.

☐ Family/caregiver does not support the antipsychotic regimen change at this time due to risk of exacerbation.

☐ Other significant barrier for antipsychotic therapy discontinuation. Please explain.

_____

☐ No

☐ **Discontinuation stage** (clinically indicated that the antipsychotic regimen can likely be successfully tapered)

☐ Member is transitioning from one antipsychotic to the other.

☐ Member is tapering antipsychotic. Please describe taper plan including duration. _____

_____

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

Please document complete treatment plan (include all antipsychotic agents [first-generation and/or second-generation] with dose/frequency/duration and indication(s) or ICD-10 code(s), if applicable, for the requested medication(s)).

_____

_____

Please select the stage of treatment and clinical rationale for use of an antipsychotic for this member < six years of age.

☐ **Acute stage** (initiation of antipsychotic treatment likely with subsequent dose adjustments to maximize response and minimize side effects)

☐ **Maintenance stage** (response to antipsychotic treatment with goal of remission or recovery)

1. Is the regimen effective, therapy benefits outweigh risks, and appropriate monitoring is in place?
   ☐ Yes ☐ No

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2. Has the member been on the requested regimen for ≥ 12 months?

☐ Yes. Please document clinical rationale for extended therapy.

☐ Previous efforts to reduce/simplify the antipsychotic regimen in the past 12 months resulted in symptom exacerbation.

☐ Family/caregiver does not support the antipsychotic regimen change at this time due to risk of exacerbation.

☐ Other significant barrier for antipsychotic therapy discontinuation. Please explain.

☐ No

☐ **Discontinuation stage** (clinically indicated that the antipsychotic regimen can likely be successfully tapered)

☐ Member is transitioning from one antipsychotic to the other.

☐ Member is tapering antipsychotic. Please describe taper plan including duration.

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.*

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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.)