



# 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.

<b>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</b>
<input type="checkbox"/> <b>MassHealth Drug Utilization Review Program</b> Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318
<b>MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)</b>
<input type="checkbox"/> <b>Fallon Health</b> Online Prior Authorization: <a href="http://go.covermy meds.com/OptumRx">go.covermy meds.com/OptumRx</a> Online Prior Authorization: <a href="http://providerportal.surescripts.net/ProviderPortal/optum">providerportal.surescripts.net/ProviderPortal/optum</a> Pharmacy: Fax: (844) 403-1029 - Tel: (844) 720-0033
<input type="checkbox"/> <b>Health New England</b> Online Prior Authorization: <a href="http://go.covermy meds.com/OptumRx">go.covermy meds.com/OptumRx</a> Pharmacy: Fax: (800) 550-9246 - Tel: (800) 918-7545
<input type="checkbox"/> <b>Mass General Brigham Health Plan</b> Online Prior Authorization (Non-Specialty Drugs): <a href="http://go.covermy meds.com/OptumRx">go.covermy meds.com/OptumRx</a> Online Prior Authorization (Specialty/Medical Drugs): <a href="http://provider.massgeneralbrighamhealthplan.org">provider.massgeneralbrighamhealthplan.org</a> Pharmacy: Fax: (844) 403-1029 - Tel: (800) 711-4555
<input type="checkbox"/> <b>Tufts Health Plan</b> Online Prior Authorization: <a href="http://point32health.promptpa.com">point32health.promptpa.com</a> Pharmacy: Fax: (617) 673-0939 - Tel: (888) 257-1985
<input type="checkbox"/> <b>WellSense Health Plan</b> Online Prior Authorization: <a href="http://wellsense.org/providers/ma/pharmacy/prior-authorizations">wellsense.org/providers/ma/pharmacy/prior-authorizations</a> Pharmacy: Fax: (833) 951-1680 - Tel: (877) 417-1822

# Hypnotic 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 hypnotic 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](http://www.mass.gov/druglist). The related PA form is available at: **Pediatric Behavioral Health Medication Initiative PA Request Form**.

## Medication information

Hypnotic requested	Qty/month	Hypnotic requested	Qty/month
<input type="checkbox"/> Belsomra (suvorexant)	<input type="text"/>	<input type="checkbox"/> zaleplon > 1 unit/day	<input type="text"/>
<input type="checkbox"/> Dayvigo (lemborexant)	<input type="text"/>	<input type="checkbox"/> zolpidem 1.75 mg, 3.5 mg sublingual	<input type="text"/>
<input type="checkbox"/> doxepin tablet	<input type="text"/>	<input type="checkbox"/> zolpidem extended-release tablet >	
<input type="checkbox"/> Edluar (zolpidem 5 mg, 10 mg sublingual)	<input type="text"/>	1 unit/day	<input type="text"/>
<input type="checkbox"/> eszopiclone > 1 unit/day	<input type="text"/>	<input type="checkbox"/> zolpidem tablet > quantity limits	<input type="text"/>
<input type="checkbox"/> Quviviq (daridorexant)	<input type="text"/>	<input type="checkbox"/> zolpidem 7.5 mg capsule	<input type="text"/>
<input type="checkbox"/> ramelteon > 1 unit/day	<input type="text"/>		

Dose and frequency

Intended duration

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

- Insomnia
  - Acute  Chronic
- Insomnia characterized by middle of the night awakenings with difficulty falling back asleep
- 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. *Please inform the member, parent, or legal guardian to expect outreach from a MassHealth representative of care coordination services.*

## Section I. Please complete for all requests exceeding the quantity limit.

Please provide medical necessity for exceeding the quantity limit.

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**Section II. Hypnotic Polypharmacy for all members. Please complete information for medications requested and select the reason for polypharmacy with hypnotics (two or more hypnotics, including benzodiazepine hypnotics [estazolam, flurazepam, quazepam, temazepam, and triazolam] and non-benzodiazepine hypnotics, for  $\geq$  60 days within a 90-day period).**

Please document complete treatment plan (include all hypnotic agents [benzodiazepine and/or non-benzodiazepine] and indication or ICD-10 code, if applicable).

1. Hypnotic name/dose/frequency  Indication

2. Hypnotic name/dose/frequency  Indication

3. Hypnotic name/dose/frequency  Indication

4. Please indicate prescriber specialty below.

Psychiatry  Neurology  Sleep Medicine  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.

5. Please describe the severity of sleep diagnosis (e.g., symptoms, recent hospitalizations, risk of harm to self or others, etc.)

Has the member had a trial with all alternative hypnotics indicated for diagnosis?

Yes. Please list the drug names, dose and frequency, dates/durations, and outcomes in Section VIII below.\*

No. If these trials are contraindicated, please describe.

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**Section III. Please complete for all requests for Belsomra, Dayvigo, and Quviviq.**

1. Has the member had a trial with two of the following: eszopiclone, ramelteon, zaleplon, or zolpidem (immediate-release or extended-release)?

Yes. Please list the drug names, dose and frequency, dates/durations, and outcomes in Section VIII below.\*

No. If these trials are contraindicated, please describe.

For Dayvigo, has the member had a trial with Belsomra?

Yes. Please list the drug names, dose and frequency, dates/durations, and outcomes in Section VIII below.\*

No. If these trials are contraindicated, please describe.

For Quviviq, has the member had a trial with Belsomra and Dayvigo?

Yes. Please list the drug names, dose and frequency, dates/durations, and outcomes in Section VIII below.\*

No. If these trials are contraindicated, please describe.

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**Section IV. Please complete for all requests for Edluar.**

Please provide medical necessity for sublingual formulation.

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**Section V. Please complete for all requests for doxepin tablet.**

1. Has the member had a trial with doxepin oral concentrate at an equivalent dose to the requested tablet or doxepin capsule?

- Yes. Please list the drug name, dose and frequency, dates/duration, and outcome in Section VIII below.\*  
 No. If these trials are contraindicated, please describe.

2. Has the member had a trial with two of the following: eszopiclone, ramelteon, Belsomra or Dayvigo or Quviviq, zaleplon, or zolpidem (immediate-release or extended-release)?

- Yes. Please list the drug name, dose and frequency, dates/duration, and outcome in Section VIII below.\*  
 No. If these trials are contraindicated, please describe.

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**Section VI. Please complete for all requests for zolpidem 1.75 mg, and 3.5 mg sublingual.**

Has the member had a trial with three of the following: eszopiclone, zaleplon, zolpidem extended-release, zolpidem immediate-release?

- Yes. Please list the drug names, dose and frequency, dates/durations, and outcomes in Section VIII below.\*  
 No. If there is a medical necessity for sublingual formulation, please describe.

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**Section VII. Please complete for all requests for zolpidem 7.5 mg capsule.**

Has the member had a trial with both of the following: zolpidem 5 mg tablet and zolpidem 10 mg tablet?

- Yes. Please list the drug names, dose and frequency, dates/durations, and outcomes in Section VIII below.\*

Please provide medical necessity for 7.5 mg capsule instead of formulations available without prior authorization.

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**Section VIII. Please complete for all requests as needed.**

Please provide the following information regarding previous trials.\*

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.

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.

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.

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.

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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

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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.**

Please document complete treatment plan listing all requested agents (include all behavioral health agents, corresponding strength, dose, directions of use and indication(s) or ICD-10 code(s), if applicable, for each medication(s)).

1.	Medication name	<input type="text"/>	Dose/frequency	<input type="text"/>	Indication	<input type="text"/>
2.	Medication name	<input type="text"/>	Dose/frequency	<input type="text"/>	Indication	<input type="text"/>
3.	Medication name	<input type="text"/>	Dose/frequency	<input type="text"/>	Indication	<input type="text"/>
4.	Medication name	<input type="text"/>	Dose/frequency	<input type="text"/>	Indication	<input type="text"/>
5.	Medication name	<input type="text"/>	Dose/frequency	<input type="text"/>	Indication	<input type="text"/>
6.	Medication name	<input type="text"/>	Dose/frequency	<input type="text"/>	Indication	<input type="text"/>
7.	Other(s)	<input type="text"/>				

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 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>

Please complete for members who have been on one of the following for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation): a polypharmacy regimen, members < six years of age who have been on an applicable behavioral health medication, and members < ten years of age who have been on an antipsychotic.

Have previous efforts to reduce or simplify the regimen in the past 24 months resulted in symptom exacerbation?  Yes  No

The family or caregiver does not support the regimen change at this time due to risk of exacerbation.

- Yes  No

Is there another significant barrier for therapy discontinuation?  Yes  No

If yes, please explain.

## Section II. Hypnotic Requests for Members < six years of age.

Please document if member has other behavioral health comorbidities (e.g., anxiety, depression, ADHD).

Please document medication trials with melatonin and/or clonidine, if clinically appropriate. Include drug name, dates/duration of use, and outcome.\*

Please document clinical rationale for the use of a hypnotic agent in this member < six years of age.

Has the member been on the requested agent for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation)?  Yes. Please complete the applicable question in Section I.  No

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

## Section III. 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 if one of the following is included: an antipsychotic, a benzodiazepine, divalproex/valproate, lithium, or a tricyclic antidepressant.

Also complete this section for all members < 18 years of age if request will result in prescriptions of five 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 monotherapy trials (include drug name, dates/duration of use, and outcome) tried before prescribing a polypharmacy regimen for this member.\*

Please document clinical rationale for use of multiple behavioral health medications for this member < 18 years of age.

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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.

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Has the member been on the requested polypharmacy regimen for the past 12 months with no adjustments (i.e., dose decrease, attempted discontinuation)?  Yes. Please complete the applicable question in Section I.  No

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

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



# Prior Authorization Request Prescriber and Provider Information

## Prescriber information

Last name*	<input type="text"/>	First name*	<input type="text"/>	MI	<input type="text"/>
NPI*	<input type="text"/>	Individual MH Provider ID	<input type="text"/>		
DEA No.	<input type="text"/>	Office Contact Name	<input type="text"/>		
Address	<input type="text"/>	City	<input type="text"/>	State	<input type="text"/>
E-mail address	<input type="text"/>				
Telephone No.*	<input type="text"/>				
Fax No.* (Please provide fax number for PA response notification.)	<input type="text"/>				

\* Required

## Please also complete for professionally administered medications, if applicable.

Start date	<input type="text"/>	End date	<input type="text"/>		
Servicing prescriber/facility name	<input type="text"/>	<input type="checkbox"/>	Same as prescribing provider		
Servicing provider/facility address	<input type="text"/>				
Servicing provider NPI/tax ID No.	<input type="text"/>				
Name of billing provider	<input type="text"/>				
Billing provider NPI No.	<input type="text"/>				
Is this a request for recertification?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
CPT code	<input type="text"/>	No. of visits	<input type="text"/>	J code	<input type="text"/>
				No. of units	<input type="text"/>

## Provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am either the prescribing provider or duly authorized to act on behalf of the provider identified in the Prescriber information section of this form. Any attached statement on 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.

### Signature of provider or individual duly authorized to act on behalf of the provider:

Printed legal name and title of signatory above

<input type="text"/>	Date	<input type="text"/>
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(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.)