



# 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.

<p><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></p> <p><input type="checkbox"/> <b>MassHealth Drug Utilization Review Program</b> Pharmacy: Fax: (877) 208-7428 - Tel: (800) 745-7318</p>
<p><b>MassHealth Managed Care Organization (MCO) and Accountable Care Partnership Plans (ACPP)</b></p> <p><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</p>
<p><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</p>
<p><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</p>
<p><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</p>
<p><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</p>

# 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](http://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)
- Onyda XR (clonidine extended-release suspension)

### 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. *Please inform the member, parent, or legal guardian to expect outreach from a MassHealth representative of care coordination services.*

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**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.

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**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.

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**Section III. Please complete for Azstarys, Cotelpla 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.

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.

  

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**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.

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**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).

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**Section VII. Please complete for Evekeo ODT requests.**

Please provide medical necessity for requested formulation instead of solid oral formulations.

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**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.

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**Section IX. Please complete for Onyda XR requests.**

1. Has the member tried clonidine immediate-release tablets 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.

2. Has the member tried clonidine patches 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.

3. Has the member tried clonidine extended-release tablets 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.

4. Is there a medical necessity for the suspension formulation instead of solid oral formulations?  Yes  No

If yes, please explain.

5. Has the member tried a liquid stimulant (amphetamine or methylphenidate product) that is available without prior authorization to treat this condition?

Yes. Please describe the drug names, dates/duration of use, and outcomes.

Drug Name

Dates/duration of use

Did member experience any of the following?  Adverse reaction  Inadequate response  Other  
Briefly describe details of adverse reaction, inadequate response, or other.

No. Please describe if there is a contraindication to all stimulants.

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**Section X. Please also complete for members  $\geq$  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.

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.

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**Section XI. 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.

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**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"/>

over

6. Medication name  Dose/frequency  Indication

7. Other(s)

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>

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**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 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.*

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**Section III. Alpha<sub>2</sub> Agonist or Cerebral Stimulant Request for Members < three years of age.**

Please document any previous medication trial(s). Include the drug name, dates/duration of use, and outcome. For requests for an amphetamine product, include drug name, dates/duration of use, and outcome to a trial with a methylphenidate product.\*

Please document clinical rationale for use of an alpha<sub>2</sub> agonist or cerebral stimulant for this member < three years of age.

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

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

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 or viloxazine 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 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.


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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**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"/>
		Zip	<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.)