Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

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**. The related PA form is available at: **Pediatric Behavioral Health Medication Initiative PA Request Form.**

Member information

Last name ______________________ First name ______________________ MI ________

MassHealth member ID # ______________ Date of birth ______________________

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Hypnotic requested	Quantity/month	Hypnotic requested	Quantity/month
☐ Belsomra (suvorexant)	________	☐ zolpidem tablet	________
☐ Edluar (zolpidem 5 mg, 10 mg sublingual)	________	☐ zolpidem extended-release tablet	________
☐ eszopiclone	________	☐ zolpidem 1.75 mg, 3.5 mg sublingual	________
☐ Rozerem (ramelteon)	________	☐ Zolpimist (zolpidem oral spray)	________
☐ Silenor (doxepin)	________		
☐ zaleplon	________		

Dose and frequency ______________________ **Intended duration** ______________________

Indication ☐ Insomnia ☐ Other ______________________

Section I. Please complete for requests for greater than 30 units/month of zaleplon and zolpidem (10mg) and for requests for greater than 45 units/month of zolpidem (5 mg).

1. Can the dose be consolidated within quantity limits (e.g., a zolpidem 5 mg, two tablets at bedtime could be dosed as zolpidem 10 mg, one tablet at bedtime)? ☐ Yes ☐ No
2. Has the member had an inadequate response to the hypnotic dosed within the quantity limit and responded to the requested dose? ☐ Yes. Please describe trial below. ☐ No. Please describe why member requires requested dose. ______________________

Section II. Please complete for all requests for zolpidem extended-release.

Has the member had a trial with zolpidem?

☐ Yes. Dates ______________________ Outcome ______________________

☐ No. If this trial is contraindicated, please describe.

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Section III. Please complete for all requests for Belsomra, eszopiclone, and Rozerem.

1. Has the member had a trial with zolpidem?
   ☐ Yes. Dates ______________________________ Outcome _______________________________________
   ☐ No. If this trial is contraindicated, please describe. ____
2. Has the member had a trial with zolpidem extended-release?
   ☐ Yes. Dates ______________________________ Outcome _______________________________________
   ☐ No. If this trial is contraindicated, please describe. ____
3. For requests for Belsomra, is the requested agent being used as monotherapy?
   ☐ Yes.
   ☐ No. Please describe the clinical rationale for combination therapy.
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Section IV. Please complete for all requests for Edluar.

Please attach supporting documentation noting a previous trial with Zolpimist including dates/duration and outcomes, and documentation of medical necessity for a sublingual formulation.

Section V. Please complete for all requests for Silenor.

Please attach supporting documentation noting previous medication trials with zolpidem, generic doxepin, and either mirtazapine or trazodone including dates/duration and outcomes.

Section VI. Please complete for all requests for Zolpimist.

Does the member require an oral spray? ☐ Yes. Please describe below. ☐ No. Describe medical necessity below.

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

Please attach supporting documentation noting previous medication trials with zolpidem, zaleplon, and zolpidem extended-release (only if requesting zolpidem 1.75 mg, 3.5 mg sublingual at a quantity > 15 units/month), including dates/duration and outcomes, or documentation of medical necessity for a sublingual formulation.

Section VIII. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

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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.

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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)

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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. ____

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.

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Psychiatric care provided is coordinated with other psychotherapeutic and community based services. ☐ Yes. ☐ No.
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.

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* *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. Hypnotic Requests for Members < six years of age.

Please document complete treatment plan (include all hypnotic agents with dose/frequency/duration and indication(s) for the requested medication(s)).

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

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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. ____________________

** 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. 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) 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.*

Prescriber information

Last name* ____________________ First name* ____________________ MI __________

NPI* ____________________ Individual MH Provider ID ____________________

DEA No. ____________________ Office Contact Name ____________________

Address ____________________ City ____________________ State __________ Zip __________

E-mail address ____________________

Telephone No.* ____________________ Fax No.* ____________________

** Required*

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 (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required ____________________

Printed name of prescribing provider ____________________ Date ____________________