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

Print Clear

Anticonvulsant 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 anticonvulsants 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

Anticonvulsant requested (Check one or all that apply.)

- ☐ Afinitor (everolimus)
- ☐ Afinitor Disperz (everolimus tablets for oral suspension)
- ☐ Aptiom (eslicarbazepine)
- ☐ Banzel (rufinamide)
- ☐ Briviact (brivaracetam solution, tablet)
- ☐ Equetro (carbamazepine extended-release)
- ☐ Fycompa (perampanel)
- ☐ Lamictal XR starter kit, lamotrigine extended-release
- ☐ lamotrigine orally disintegrating tablet (ODT), ODT starter kit
- ☐ lamotrigine tablet starter kit
- ☐ Lyrica (pregabalin)
- ☐ Onfi (clobazam)
- ☐ Oxtellar XR (oxcarbazepine extended-release)
- ☐ Qudexy XR (topiramate extended-release capsule)
- ☐ Spritam (levetiracetam tablet for oral suspension)
- ☐ tiagabine
- ☐ Trokendi XR (topiramate extended-release capsule)
- ☐ vigabatrin
- ☐ Vimpat (lacosamide solution, tablet)

Dose, frequency, and duration of requested drug _____

Drug NDC (if known) or service code _____

Indication (Check all that apply.)

- ☐ Bipolar disorder
- ☐ Diabetic peripheral neuropathy
- ☐ Epilepsy or seizure disorder
  Type _____
- ☐ Epilepsy associated with tuberous sclerosis complex
- ☐ Fibromyalgia
- ☐ Infantile spasms
- ☐ Migraine prophylaxis
- ☐ Pain associated with trigeminal neuralgia
- ☐ Postherpetic neuralgia
- ☐ Other (describe) _____
  _____
  _____

Please list all other medications currently prescribed for the member for this indication.

_____

_____

Please indicate prescriber specialty below.

☐ Neurology ☐ Psychiatry ☐ 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.

_____

Section I. Please complete for all requests for epilepsy or seizure disorder, excluding lamotrigine agents.

Please provide the following information regarding previous trials.*

1. Drug _____ Dates of Use _____ Outcome _____
2. Drug _____ Dates of Use _____ Outcome _____
3. Drug _____ Dates of Use _____ Outcome _____

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

Section II. Please also complete for requests for Equetro, Lamictal XR starter kit, lamotrigine extended-release, Oxtellar XR, Qudexy XR, Spritam, and Trokendi XR.

For Lamictal XR starter kit, lamotrigine extended-release, and diagnoses other than epilepsy or seizure disorder, only question 1 is required.

1. Please provide medical necessity for the use of the requested formulation instead of the respective formulation(s) that is available without prior authorization.

   _____

2. Has the member been stabilized on the requested agent (any form)? ☐ Yes ☐ No

Section III. Please also complete for requests for Lyrica.

For requests for epilepsy or seizure disorder, please complete question 1. For requests for fibromyalgia, please complete questions 2 and 3. For requests for diabetic peripheral neuropathy or postherpetic neuralgia, please complete questions 3 and 4.

1. Has the member experienced an inadequate response or adverse reaction to other anticonvulsants?
   ☐ Yes. Please complete Section I above.
   ☐ No. Explain medical necessity for the use of Lyrica.

   _____

2. Has the member experienced an inadequate response (four weeks of therapy) or adverse reaction to a tricyclic antidepressant (TCA), an SSRI-type antidepressant, an SNRI-type antidepressant, or cyclobenzaprine?
   ☐ Yes. Please describe trial(s) below.
   Drug _____ Dates of Use _____ Outcome _____
   ☐ No. Explain why a TCA, an SSRI and SNRI-type antidepressant, and cyclobenzaprine have not been tried.

   _____

3. Has the member experienced an inadequate response (two weeks of therapy at 1,200 mg/day) or adverse reaction to gabapentin?
   ☐ Yes. Please describe trial below.
   Dose and frequency _____ Dates of Use _____ Outcome _____
   ☐ No. Explain why gabapentin has not been tried.

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4. Has the member experienced an inadequate response (four weeks of therapy) or adverse reaction to a tricyclic antidepressant (TCA), duloxetine, lidocaine patch, or venlafaxine?
   ☐ Yes. Please describe trial below.
   Drug _____ Dates of Use _____ Outcome _____
   ☐ No. Explain why a TCA, duloxetine, lidocaine patch, and venlafaxine have not been tried.
   _____

Section IV. Please complete for requests for lamotrigine ODT.

1. Does the member have a medical condition in which they are not able to swallow pills?
   ☐ Yes. Please describe. _____ ☐ No
2. Has the member experienced an inadequate response or adverse reaction to lamotrigine dispersible tablets?
   ☐ Yes. Please describe trial below.
   Dose and frequency _____ Dates of Use _____ Outcome _____
   ☐ No. Explain why lamotrigine dispersible tablets have not been tried.
   _____

Section V. 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.

_____

_____

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 _____

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 _____

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☐ 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.

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.

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 service would be beneficial.

** 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. Mood Stabilizer Polypharmacy. Complete this section for all members < 18 years of age, if request will result in prescription of three or more mood stabilizers for ≥ 60 days within a 90-day period.

Please document complete treatment plan (include all mood stabilizing agents).

1. Mood stabilizer name/dose/frequency _____ Indication _____
2. Mood stabilizer name/dose/frequency _____ Indication _____
3. Mood stabilizer name/dose/frequency _____ Indication _____
4. Mood stabilizer name/dose/frequency _____ Indication _____
5. Other(s) _____

Please document if monotherapy trials (include drug name, dates/duration of use, and outcome) with mood stabilizers were tried before prescribing polypharmacy with three or more mood stabilizers 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. Mood Stabilizer Request for Members < six years of age (agents considered to be used only for seizure diagnoses are not included).

Please document complete treatment plan (include all mood stabilizer agents with dose/frequency/duration and indication(s) 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 a mood stabilizer for this member < six years of age.

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

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) 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*

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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 _____