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

Benzodiazepines and Other Antianxiety 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 benzodiazepines or other antianxiety 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

Medication requested (check one or all that apply.)

☐ alprazolam extended-release (ER) >60 units/month
☐ alprazolam orally disintegrating tablet (ODT)
☐ clonazepam ODT 0.125 mg, 0.25 mg, 0.5 mg, 1 mg >90 units/month
☐ clonazepam ODT 2 mg
☐ diazepam rectal gel >5 kits (10 syringes)/month
☐ estazolam >30 units/month
☐ flurazepam >30 units/month
☐ meprobamate
☐ temazepam 7.5 mg, 15 mg, 30 mg >30 units/month
☐ temazepam 22.5 mg
☐ triazolam >30 units/month
☐ 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 and frequency _____ **Quantity requested per month** _____
Intended duration _____
Indication(s) _____

Section I. Benzodiazepine Polypharmacy for members ≥ 18 years of age. Please complete information for medications requested and clinical rationale for polypharmacy with benzodiazepines (two or more benzodiazepines, excluding clobazam, rectal diazepam, and injectable formulations for ≥ 60 days within a 90-day period).

Please document complete treatment plan for the agents requested from the same medication class.

1. Benzodiazepine name/dose/frequency _____ Indication _____
2. Benzodiazepine name/dose/frequency _____ Indication _____
3. Benzodiazepine name/dose/frequency _____ Indication _____

Please document clinical rationale for polypharmacy within the same medication class for this member (include prior therapy trials, severity of symptoms, etc.)

_____

_____

Has consideration been given for consolidation to a single benzodiazepine agent?

☐ Yes. Please describe plan for cross-titration or taper. _____

☐ No

Please describe why dose consolidation is not possible at this time and plan to reevaluate in the future.

_____

_____

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 risk of harm to self or others?

☐ Yes. Please provide details.

_____

☐ No

Section II. Please complete for requests for alprazolam ODT, clonazepam ODT 2 mg, and diazepam rectal gel (>5 kits/month).

Please describe the medical necessity for use of the requested dosage formulation, and/or use over quantity limits. Include prior trials of agents as appropriate. For alprazolam ODT, describe dose consolidation.

_____

_____

Section III. Please complete for requests for > 30 units/month of estazolam, flurazepam, temazepam (7.5 mg, 15 mg, and 30 mg), and triazolam, > 60 units/month of alprazolam ER, and >90 units/month of clonazepam ODT.

1. Can the dose be consolidated within quantity limits? ☐ Yes ☐ No
2. Please describe medical necessity for exceeding the quantity limit.

   _____
3. For clonazepam ODT, 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 _____

Section IV. Please complete for requests for temazepam 22.5 mg.

Please attach medical records documenting an inadequate response or adverse reaction to all hypnotic benzodiazepines (e.g., estazolam, flurazepam, temazepam 7.5 mg, 15 mg, or 30 mg, triazolam). Please describe dose consolidation. For requests for > 30 units/month, describe medical necessity for exceeding the quantity limit.

Section V. Please complete for requests for meprobamate.

1. Has the member had a trial with at least two benzodiazepines?

   ☐ Yes

   Drug name _____ Dates _____ Outcome _____

   Drug name _____ Dates _____ Outcome _____

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☐ No. Please explain why not. _____

2. If requesting continuation of therapy, please provide clinical rationale for continued therapy and details of trials with alternatives (e.g., SSRIs, SNRIs, TCAs, buspirone).

_____

Section VI. 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 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. _____

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 _____

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Please document agency involvement.

☐ Department of Children and Families (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, 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 services 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. Benzodiazepine Polypharmacy. Complete this section for all members < 18 years of age, if request will result in prescription of two or more benzodiazepine agents for ≥ 60 days within a 90-day period (excluding hypnotic benzodiazepine agents, clobazam, rectal diazepam, and injectable formulations.

Please document complete treatment plan (include all benzodiazepine agents).

1. Benzodiazepine name/dose/frequency _____ Indication _____
2. Benzodiazepine name/dose/frequency _____ Indication _____
3. Benzodiazepine name/dose/frequency _____ Indication _____
4. Other(s) _____

Please document if monotherapy trials (include drug name, dates/duration of use, and outcome) with benzodiazepine agents were tried before prescribing polypharmacy with two or more benzodiazepine agents 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.*

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

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

_____

_____

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

_____

For hypnotic benzodiazepine requests, please document medication trials with melatonin and/or clonidine, if clinically appropriate. Include drug name, dates/duration of use, and outcome.*

_____

_____

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Please document clinical rationale for the use of a benzodiazepine agent in 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*

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 _____