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

Print Clear

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	Qty/month	Hypnotic requested	Qty/month
☐ Belsomra (suvorexant)	_____	☐ zolpidem 1.75 mg, 3.5 mg sublingual	_____
☐ Edluar (zolpidem 5 mg, 10 mg sublingual)	_____	☐ zolpidem extended-release tablet > 30 units/month	_____
☐ eszopiclone > 30 units/month	_____	☐ zolpidem tablet > quantity limits	_____
☐ Rozerem (ramelteon) > 30 units/month	_____	☐ Zolpimist (zolpidem oral spray)	_____
☐ Silenor (doxepin tablet)	_____		
☐ zaleplon > 30 units/month	_____		

Dose and frequency _____ **Intended duration** _____

Indication (Check all that apply.)
☐ Insomnia
☐ Insomnia characterized by middle of the night awakenings with difficulty falling back asleep
☐ Other _____

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

Please provide medical necessity for exceeding the quantity limit.

_____
_____

Section II. Please complete for all requests for Belsomra.

Has the member had a trial with two of the following: eszopiclone, Rozerem, zaleplon, or zolpidem (immediate-release or extended-release)?
☐ Yes. Please list the drug names, dose and frequency, dates/durations, and outcomes in Section VII below.*
☐ No. If these trials are contraindicated, please describe.

_____

Section III. Please complete for all requests for Edluar.

Please provide clinical rationale for sublingual formulation.

____

Section IV. Please complete for all requests for Silenor.

Has the member had a trial with one of the following: doxepin (capsule or liquid), eszopiclone, Rozerem, zaleplon, or zolpidem (immediate-release or extended-release)?

☐ Yes. Please list the drug name, dose and frequency, dates/duration, and outcome in Section VII below.*

☐ No. If these trials are contraindicated, please describe.

____

Section V. Please complete for all requests for Zolpimist.

1. Has the member had a trial with all of the following: Belsomra, doxepin (capsule, liquid, or tablets), eszopiclone, Rozerem, zaleplon, zolpidem (immediate-release or extended-release)?
   ☐ Yes. Please list the drug names, dose and frequency, dates/durations, and outcomes in Section VII below.*
   ☐ No. If these trials are contraindicated, please describe.
   ____
2. Please provide clinical rationale for non-tablet dosage formulation.
   ____
3. Please provide medical necessity for use instead of zolpidem sublingual tablets.
   ____

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 VII below.*

☐ No. If there is a clinical rationale for sublingual formulation, please describe.

____

Section VII. 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 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.

_____

_____

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

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 _____

☐ 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)

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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 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. 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)).

_____

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.

_____

** 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.*

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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 _____