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

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# Antidepressant 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 antidepressants 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

**Antidepressant requested**

☐ Aplenzin (bupropion hydrobromide extended-release)
☐ bupropion XL > 30 units/month
☐ bupropion hydrochloride extended-release 450 mg tablet
☐ clomipramine
☐ desipramine
☐ desvenlafaxine extended-release
☐ desvenlafaxine succinate extended-release
☐ duloxetine 40 mg
☐ Emsam (selegiline)
☐ Fetzima (levomilnacipran)
☐ fluoxetine 20 mg tablet for PMDD
☐ fluoxetine 60 mg tablet
☐ fluoxetine 90 mg delayed-release capsule
☐ fluvoxamine extended-release
☐ imipramine pamoate tablet
☐ Khedezla (desvenlafaxine extended-release)
☐ Marplan (isocarboxazid)
☐ mirtazapine orally disintegrating tablet
☐ olanzapine/fluoxetine
☐ paroxetine controlled-release
☐ Pexeva (paroxetine mesylate)
☐ Spravato (esketamine)
☐ trazodone 300 mg tablet
☐ Trintellix (vortioxetine)
☐ venlafaxine extended-release tablets
☐ Viibryd (vilazodone)
☐ 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** _____
Drug NDC (if known) _____

**Indication** (Check all that apply.)

☐ Depression ☐ Panic disorder ☐ Obsessive-compulsive disorder ☐ Premenstrual dysphoric disorder
☐ Other (describe) _____
_____

Please list all other psychotropic medications currently prescribed for the member.

_____

_____

Has member been hospitalized for this condition? ☐ Yes. Dates of most recent hospitalization _____
☐ No

Is the member under the care of psychiatrist? ☐ Yes ☐ No
Name of psychiatrist _____
Telephone no. _____ Date of last visit or consult with psychiatrist _____

**Section I. Please complete for Aplenzin, bupropion hydrochloride extended-release 450 mg tablet, desvenlafaxine extended-release, desvenlafaxine succinate extended-release, duloxetine 40 mg, fluoxetine 20 mg and 60 mg tablet, fluoxetine 90 mg delayed-release capsule, fluvoxamine extended-release, imipramine pamoate, Khedezla (desvenlafaxine extended-release), paroxetine controlled-release, Pexeva, trazodone 300 mg tablet, and venlafaxine extended-release tablet.**

Please attach medical records documenting an inadequate response (defined as at least four weeks of therapy) or adverse reaction to the respective formulation of the agent requested that is available without prior authorization. For Aplenzin, in addition attach medical records of bupropion hydrochloride extended-release 450 mg tablet trial. For Pexeva, in addition attach medical records of paroxetine controlled-release trial.

**Section II. Please complete for requests for clomipramine, desipramine, Fetzima, Marplan, Trintellix, and Viibryd.**

Please describe applicable antidepressant trials and outcomes (attach a letter with additional information regarding trials as applicable).

Drug name _____ Dates/duration 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.

_____

Drug name _____ Dates/duration 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.

_____

**Section III. Please complete for requests for Emsam.**

1. Has the member had a trial with one SSRI and one non-SSRI antidepressant?

☐ Yes. Please list the drug name, dose and frequency, dates/duration of trials, and outcomes below.
Drug name _____ Dates/duration of use _____ Dose and frequency _____
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 _____ Dates/duration of use _____ Dose and frequency _____
Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other
Briefly describe details of adverse reaction, inadequate response, or other.

_____

☐ No. Please explain why not. _____

2. Is there a medical necessity for the transdermal formulation? ☐ Yes ☐ No
If yes, please explain. _____

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**Section IV. Please complete for requests for mirtazapine orally disintegrating tablet.**

Is there a medical necessity for the orally disintegrating formulation?

☐ Yes. Please explain. _____

_____

☐ No Please attach medical records documenting an inadequate response (defined as at least four weeks of therapy) or adverse reaction to generic mirtazapine tablet.

**Section V. Please complete for requests for olanzapine/fluoxetine.**

Please describe the medical necessity for use of the combination product over the separately available ingredients.

_____

_____

**Section VI. Please complete for requests for Spravato.**

1. Please attach medical records documenting a trial with one SSRI and one non-SSRI antidepressant.
2. Please attach medical records documenting a trial with one of the following antidepressant augmentation strategies: second-generation antipsychotic, lithium, a second antidepressant from a different class, thyroid hormone. If there is a contraindication to all antidepressant augmentation strategies, attach medical records documenting the contraindication.
3. Will the requested agent be used in combination with an oral antidepressant? ☐ Yes ☐ No

**Section VII. Please complete for requests for bupropion XL > 30 units/month.**

Please attach medical records documenting medical necessity for quantities above 30 units/month.

**Section VIII. Antidepressant Polypharmacy for members ≥ 18 years of age. Please complete information for medications requested and select the reason for polypharmacy with antidepressants (two or more SSRI, SNRI, or Serotonin Modulator antidepressants for ≥ 60 days within a 90-day period).**

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

Please document clinical rationale for polypharmacy within the same medication class for this member.

_____

_____

**Section IX. 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

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: ☐ 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)

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*

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**Section II. Antidepressant Polypharmacy. Complete this section for all members < 18 years of age, if request will result in prescription of two or more antidepressants ≥ 60 days within a 90-day period.**

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

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

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

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_____

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. Antidepressant Request for Members < six years of age.**

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

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_____

Please document any previous medication trial(s). Include the drug name, dates/duration of use, and outcome.*

_____

_____

Please document clinical rationale for use of an antidepressant for this member < six years of age.

_____

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

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**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 _____

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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 _____