



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

## 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](http://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.)

- |   |   |
|---|---|
| <input type="checkbox"/> alprazolam extended-release (ER) >60 units/month               | <input type="checkbox"/> flurazepam >30 units/month                     |
| <input type="checkbox"/> alprazolam orally disintegrating tablet (ODT)                  | <input type="checkbox"/> meprobamate                                    |
| <input type="checkbox"/> clonazepam ODT 0.125 mg, 0.25 mg, 0.5 mg, 1 mg >90 units/month | <input type="checkbox"/> temazepam 7.5 mg, 15 mg, 30 mg >30 units/month |
| <input type="checkbox"/> clonazepam ODT 2 mg  | <input type="checkbox"/> temazepam 22.5 mg                              |
| <input type="checkbox"/> diazepam rectal gel >5 kits (10 syringes)/month                | <input type="checkbox"/> triazolam >30 units/month                      |
| <input type="checkbox"/> estazolam >30 units/month                                      | <input type="checkbox"/> 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.)

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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.

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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

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**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.

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**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 \_\_\_\_\_

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**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.

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**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 \_\_\_\_\_  
over

No. Please explain why not. \_\_\_\_\_

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

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**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.

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\_\_\_\_\_

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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.**

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**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 \_\_\_\_\_

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.\*

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 \_\_\_\_\_