



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

## Pediatric Behavioral Health Medication Initiative 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.

The **Pediatric Behavioral Health Medication Initiative** requires prior authorization for pediatric members (generally members < 18 years of age) for certain behavioral health medication classes and/or specific medication combinations (i.e. polypharmacy) that have limited evidence for safety and efficacy in the pediatric population. For a comprehensive medication list and additional information about the **Pediatric Behavioral Health Medication Initiative**, including PA requirements and preferred products please refer to the MassHealth Drug List at [www.mass.gov/druglist](http://www.mass.gov/druglist).

### 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

#### 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)

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. Polypharmacy within the same medication class (e.g., antidepressants, benzodiazepines, cerebral stimulants, mood stabilizers). Complete this section for all members < 18 years of age if request will result in polypharmacy within the same medication class.**

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

- 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. Other(s) \_\_\_\_\_

Please document if monotherapy trials (include drug name, dates/duration of use, and outcome) were tried before prescribing polypharmacy with two or more agents within the same medication class for this member.\*\*

Please document clinical rationale for polypharmacy within the same medication class 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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**Section III. Antipsychotic Polypharmacy. Complete this section for all members < 18 years of age if request will result in prescription of two or more antipsychotics for ≥ 60 days within a 90-day period.**

Please document complete treatment plan (include all antipsychotic agents [first-generation and/or second-generation]).

1. Antipsychotic name/dose/frequency \_\_\_\_\_ Indication \_\_\_\_\_
2. Antipsychotic name/dose/frequency \_\_\_\_\_ Indication \_\_\_\_\_
3. Antipsychotic name/dose/frequency \_\_\_\_\_ Indication \_\_\_\_\_
4. Other(s) \_\_\_\_\_

Please select the stage of treatment and clinical rationale for antipsychotic polypharmacy.

**Acute stage** (initiation of antipsychotic treatment likely with subsequent dose adjustments to maximize response and minimize side effects)

Member experienced an inadequate response or adverse reaction to two monotherapy trials with antipsychotics.

Drug name 1 \_\_\_\_\_ Dates/Duration of use \_\_\_\_\_

Drug name 2 \_\_\_\_\_ Dates/Duration of use \_\_\_\_\_

Member is transitioning from one antipsychotic to the other.

Other, please explain. \_\_\_\_\_

**Maintenance stage** (response to antipsychotic treatment with goal of remission or recovery)

1. Is the regimen effective, therapy benefits outweigh risks, and appropriate monitoring is in place?

Yes  No

2. Has the member been on the requested regimen for ≥ 12 months?

Yes. Please document clinical rationale for extended therapy.

Previous efforts to reduce/simplify the antipsychotic regimen in the past 24 months resulted in symptom exacerbation.

Family/caregiver does not support the antipsychotic regimen change at this time due to risk of exacerbation.

Other significant barrier for antipsychotic therapy discontinuation. Please explain.

\_\_\_\_\_  
 No

**Discontinuation stage** (clinically indicated that the antipsychotic regimen can likely be successfully tapered)

Member is transitioning from one antipsychotic to the other.

Member is tapering antipsychotic. Please describe taper plan including duration.

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**Section IV. Behavioral Health Medication [e.g., antidepressant, atomoxetine, benzodiazepine, buspirone, or mood stabilizer (agents considered to be used only for seizure diagnoses are not included)] for members < six years of age.**

Please document complete treatment plan (medication name/dose/frequency/duration and indication) for the requested behavioral health medication(s).

\_\_\_\_\_

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

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Please document clinical rationale for use of an antidepressant, atomoxetine, benzodiazepine, buspirone, or mood stabilizer for this member < six years of age.

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**Section V. Antipsychotic Request for Members < six years of age.**

Please document complete treatment plan (include all antipsychotic agents [first-generation and/or second-generation] with dose/frequency/duration and indication(s) for the requested medication(s)).

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Please select the stage of treatment and clinical rationale for use of an antipsychotic for this member < six years of age.

- Acute stage** (initiation of antipsychotic treatment likely with subsequent dose adjustments to maximize response and minimize side effects)
  - Maintenance stage** (response to antipsychotic treatment with goal of remission or recovery)
    1. Is the regimen effective, therapy benefits outweigh risks, and appropriate monitoring is in place?  
 Yes  No
    2. Has the member been on the requested regimen for  $\geq 12$  months?  
 Yes. Please document clinical rationale for extended therapy.
      - Previous efforts to reduce/simplify the antipsychotic regimen in the past 12 months resulted in symptom exacerbation.
      - Family/caregiver does not support the antipsychotic regimen change at this time due to risk of exacerbation.
      - Other significant barrier for antipsychotic therapy discontinuation. Please explain.
  - No
  - Discontinuation stage** (clinically indicated that the antipsychotic regimen can likely be successfully tapered)
    - Member is transitioning from one antipsychotic to the other.
    - Member is tapering antipsychotic. Please describe taper plan including duration.
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**Section VI. Alpha<sub>2</sub> Agonist or Cerebral Stimulant Request for Members < three years of age.**

Please document complete treatment plan (medication name/dose/frequency/duration and indication) for the requested alpha<sub>2</sub> agonist and/or cerebral stimulant medication(s).

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

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Please document clinical rationale for use of an alpha<sub>2</sub> agonist and/or cerebral stimulant for this member < three years of age.

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

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**Section VII. Hypnotic Request for Members < six years of age.**

Please document complete treatment plan (medication name/dose/frequency/duration and indication) for the requested hypnotic medication(s).

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

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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 hypnotic agent 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 VIII. 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.\*\*

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Please document clinical rationale for use of multiple behavioral health medications for this member < 18 years of age.

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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.

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

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