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

Cerebral Stimulant and ADHD Drugs 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 ADHD medications 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 all that apply. Where applicable, the brand name is provided in brackets for reference.)

Long-Acting Cerebral Stimulants

- ☐ amphetamine salts extended-release [Adderall XR] > 60 units/ month
- ☐ Adhansia XR (methylphenidate extended-release)
- ☐ Adzenys ER (amphetamine extended-release oral suspension)
- ☐ Adzenys XR-ODT (amphetamine extended-release orally disintegrating tablet)
- ☐ Aptensio XR (methylphenidate extended-release)
- ☐ Cotempla XR-ODT (methylphenidate extended-release orally disintegrating tablet)
- ☐ Daytrana (methylphenidate transdermal)
- ☐ dexmethylphenidate extended-release [Focalin XR] > 60 units/ month
- ☐ Dyanavel XR (amphetamine extended-release oral suspension)
- ☐ Jornay PM (methylphenidate extended-release)
- ☐ methylphenidate extended-release [Concerta] > 60 units/month
- ☐ methylphenidate extended-release 72 mg tablet
- ☐ methylphenidate extended-release [Metadate CD]
- ☐ methylphenidate extended-release [Ritalin LA]
- ☐ Mydayis (amphetamine salts extended-release)
- ☐ Quillichew ER (methylphenidate extended-release chewable tablet)
- ☐ Quillivant XR (methylphenidate extended-release oral suspension)
- ☐ Vyvanse (lisdexamfetamine) > 60 units/month

Intermediate/Short-Acting Cerebral Stimulants

- ☐ amphetamine salts [Adderall] > 90 units/month
- ☐ amphetamine sulfate
- ☐ dexmethylphenidate [Focalin] > 90 units/month
- ☐ dextroamphetamine 5 mg, 10 mg, 15 mg capsule [Dexedrine] > 90 units/month
- ☐ dextroamphetamine 2.5 mg, 7.5 mg, 15 mg, 20 mg, 30 mg tablet
- ☐ dextroamphetamine 5 mg, 10 mg tablet > 90 units/month
- ☐ dextroamphetamine solution > 900 mL/month
- ☐ Evekeo ODT (amphetamine sulfate orally disintegrating tablet)
- ☐ methylphenidate [Ritalin] > 90 units/month
- ☐ methylphenidate chewable tablet > 90 units/month
- ☐ methylphenidate oral solution [Methylin oral solution] > 900 mL/ month
- ☐ methylphenidate sustained-release tablet > 90 units/month

Non-Stimulant Medication

☐ clonidine extended-release tablet

Other Medication

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 _____

Indication (Check all that apply.)

☐ Attention Deficit Hyperactivity Disorder (ADHD) ☐ Narcolepsy ☐ Other _____

Quantity requested per month _____ **Total quantity of all stimulants combined** _____

Section I. Please complete for cerebral stimulant requests above quantity limits.

1. Has dose consolidation been attempted? ☐ Yes ☐ No. Please explain why not.

   _____

2. Is the member under the care of a psychiatrist or behavioral specialist? ☐ Yes ☐ No
3. Please list all medications currently prescribed for this member for this condition.

   _____

   _____

4. Please describe your new treatment plan for managing this member's condition, including discontinuation of any medications as a result of the addition of medication requested.

   _____

   _____

Section II. Please complete for clonidine extended-release tablet requests.

1. Has member tried medications in the methylphenidate class to treat this condition?

   ☐ Yes. Complete part A. ☐ No. Explain why not. _____

   A. Drug name _____ Dates 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.

   _____

2. Has member tried medications in the amphetamine/dextroamphetamine class to treat this condition?

   ☐ Yes. Complete part B. ☐ No. Explain why not. _____

   B. Drug name _____ Dates 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.

   _____

3. Has member tried clonidine immediate-release to treat this condition?

   ☐ Yes. Complete part C. ☐ No. Explain why not. _____

   C. Dates 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 dextroamphetamine 2.5 mg, 7.5 mg, 15 mg, 20 mg, and 30 mg tablet requests.

Please provide medical necessity for requested strength over dextroamphetamine 5 mg and 10 mg tablets.

_____

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Section IV. Please complete for Adhansia XR, Aptensio XR, Cotempla XR-ODT, Daytrana, Jornay PM, methylphenidate extended-release [Metadate CD, Ritalin LA], Quillichew ER, and Quillivant XR requests.

Please provide clinical rationale for use of the requested agent instead of Concerta (methylphenidate extended-release) and Focalin XR (dexmethylphenidate extended-release).

_____

Section V. Please complete for amphetamine sulfate requests.

Has the member tried a generic amphetamine product to treat this condition?

☐ Yes. Attach documentation of trials, including drug name, dose and frequency, dates of use, and outcomes.

☐ No. Explain why not. _____

Section VI. Please complete for methylphenidate extended-release 72 mg tablet requests.

Please provide clinical rationale for requested strength instead of two Concerta (methylphenidate extended-release) 36 mg tablets and Focalin XR (dexmethylphenidate extended-release).

_____

Section VII. Please complete for Evekeo ODT requests.

Please provide clinical rationale for requested formulation instead of the solid oral formulation.

_____

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.

_____

_____

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

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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. Cerebral Stimulant Polypharmacy. Complete this section for all members < 18 years of age, if request will result in prescription of two or more cerebral stimulants for ≥ 60 days within a 90-day period. Please note, immediate-release and extended-release formulations of the same chemical entity are counted as one.

Please document complete treatment plan (include all cerebral stimulant agents).

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

Please document amphetamine and methylphenidate monotherapy trials (include drug name, dates/duration of use, and outcome) and rationale for polypharmacy with two or more cerebral stimulants 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.*

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Section III. Alpha$_2$ Agonist or Cerebral Stimulant Request for Members < three years of age.

Please document complete treatment plan (include all alpha$_2$ agonist and/or stimulant agents with dose/frequency/duration and indication(s) for the requested medication(s)).

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 alpha$_2$ agonist or cerebral stimulant for this member < three years of age.

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

Section IV. Atomoxetine Request for Members < six years of age.

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

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

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

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

Section V. 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 _____