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

Antipsychotic 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 antipsychotics 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(s) requested along with dose and frequency.

- ☐ Abilify Maintena (aripiprazole extended-release injection)
- ☐ Abilify Mycite (aripiprazole tablet with sensor)
- ☐ aripiprazole orally disintegrating tablet (ODT)
- ☐ aripiprazole solution ≥ 18 years old and > 750 mL/month
- ☐ aripiprazole tablet > 30 units/month
- ☐ clozapine ODT
- ☐ Fanapt (iloperidone)
- ☐ Latuda (lurasidone)
- ☐ olanzapine ODT > quantity limits
- ☐ olanzapine tablet > quantity limits
- ☐ paliperidone tablet
- ☐ Perseris (risperidone extended-release subcutaneous injection)
- ☐ quetiapine > 90 units/month
- ☐ quetiapine extended-release > quantity limits
- ☐ Rexulti (brexpiprazole)
- ☐ risperidone 0.25 mg, 4 mg ODT
- ☐ risperidone 0.5 mg, 1 mg, 2 mg, 3 mg ODT > quantity limits
- ☐ risperidone solution > 480 mL/month
- ☐ risperidone tablet > quantity limits
- ☐ Saphris (asenapine sublingual tablet)
- ☐ Secuado (asenapine transdermal)
- ☐ Versacloz (clozapine suspension)
- ☐ Vraylar (cariprazine)
- ☐ ziprasidone > 60 units/month
- ☐ Other _____

Dose and frequency of medication requested _____

Indication (Check all that apply.)

- ☐ Bipolar disorder
- ☐ Irritability associated with autistic disorder
- ☐ Major depressive disorder
- ☐ Psychosis, unspecified
- ☐ Schizophrenia
- ☐ Treatment-resistant depression
- ☐ Other _____

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.

_____

_____

Section I. Monotherapy

Please select previous medication trial(s) as applicable.*

**For aripiprazole ODT or solution for irritability associated with autistic disorder, a trial with risperidone alone is sufficient. For Perseris requests, please document a trial of Risperdal Consta or Invega Sustenna, or provide clinical rationale for use of Perseris instead of these agents.*

☐ Trial(s) of second-generation (atypical) antipsychotics (Check all that apply.)
☐ aripiprazole ☐ clozapine ☐ olanzapine ☐ quetiapine ☐ risperidone ☐ ziprasidone ☐ Other _____

☐ Trial of other antipsychotics (Please specify below.)
Drug name 1 _____ Drug name 2 _____

☐ If requesting for major depressive disorder or treatment-resistant depression, please document trial of two antidepressants.
Drug name 1 _____ Dates/Duration of use _____
Drug name 2 _____ Dates/Duration of use _____

Please select reason(s) for medical necessity as applicable.

☐ Member is new to MassHealth and has been previously stabilized on requested medication.

☐ If request is for major depressive disorder or treatment-resistant depression, please note if the requested agent will be used as adjunctive therapy with current antidepressant treatment or provide clinical rationale why the member is not a candidate for antidepressant therapy.

_____

_____

☐ If requesting ODT, solution, or transdermal formulation, please also describe medical necessity for the specific dosage form.

_____

_____

☐ If requesting Abilify Mycite, please also describe the medical necessity for monitoring the member's ingestion of oral aripiprazole, and the member's training to use the Abilify Mycite system.

_____

_____

☐ Other, please explain.

_____

_____

Section II. Antipsychotic Polypharmacy for members ≥ 18 years of age. Please complete information for medications requested and select the reason for polypharmacy with antipsychotics (two or more first-generation and/or second-generation antipsychotics for ≥ 60 days within a 90-day period).

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

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Is member under the care of a psychiatrist?

☐ Yes. Please attach specialist consult details (if the prescriber submitting the request is not a specialist). ☐ No

For mid-level practitioners (e.g., nurse practitioners, physician assistants), please provide the name and specialty of the collaborating physician.

_____

☐ Member was recently discharged from an inpatient setting on requested medications and is currently stable.

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

Drug name 1 _____ Dates/Duration of use (if available) _____

Drug name 2 _____ Dates/Duration of use (if available) _____

☐ Member is transitioning from one antipsychotic to the other.

☐ Other, please explain. _____

Section III. Quantity Limits. Please complete information for medication requested and select the reason for exceeding established quantity limits.

Drug, dose, and frequency of requested antipsychotic _____

☐ Member is not a candidate for dose consolidation (e.g., olanzapine 5 mg twice daily can be consolidated to olanzapine 10 mg once daily, which does not require PA).

☐ Other. Please describe medical necessity for exceeding quantity limits.

_____

_____

Section IV. 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

* *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. 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. _____

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☐ **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. _____

_____

Section III. 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)).

_____

_____

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 ≥ 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 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 _____