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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

# 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

**Medication requested**

- ☐ Aplenzin (bupropion hydrobromide extended-release) > 1 unit/day
- ☐ bupropion XL > 1 unit/day
- ☐ bupropion hydrochloride extended-release 450 mg tablet
- ☐ clomipramine
- ☐ desipramine
- ☐ desvenlafaxine extended-release
- ☐ desvenlafaxine succinate extended-release > 1 unit/day
- ☐ Drizalma (duloxetine sprinkle capsule)
- ☐ duloxetine 40 mg capsule
- ☐ Emsam (selegiline)
- ☐ Fetzima (levomilnacipran) > 1 unit/day
- ☐ 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)
- ☐ Zulresso (brexanolone)^
- ☐ 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).*

*^ This drug is available through the health care professional who administers the drug. MassHealth does not pay for this drug to be dispensed through a retail pharmacy.*

**Dose, frequency, and duration of medication requested** _____
Drug NDC (if known) _____

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

- ☐ Major depressive disorder
- ☐ Obsessive-compulsive disorder
- ☐ Panic disorder
- ☐ Postpartum depression
- ☐ 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 _____

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. Please complete for bupropion hydrochloride extended-release 450 mg tablet, desvenlafaxine extended-release, duloxetine 40 mg capsule, fluoxetine 60 mg tablet, fluoxetine 90 mg delayed-release capsule, fluvoxamine extended-release, imipramine pamoate, Khedezla, 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 Pexeva, in addition attach medical records of paroxetine controlled-release trial.

**Section II. Please complete for requests for clomipramine, desipramine, 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 Drizalma and mirtazapine orally disintegrating tablet.**

Is there a medical necessity for the specific dosage form?

☐ Yes. Please explain. _____

_____

☐ No. If the request is for mirtazapine orally disintegrating tablet, please attach medical records documenting an inadequate response (defined as at least four weeks of therapy) or adverse reaction to 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.**

For requests for treatment resistant depression, please complete questions 1, 2, and 4. Initial requests for major depressive disorder with acute suicidal ideation or behavior, please complete questions 3 and 4. Subsequent requests for major depressive disorder with acute suicidal ideation or behavior should complete the questions for treatment resistant depression.

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. Please attach medical records documenting either current acute suicidal ideation or behavior related to depressive symptoms of major depressive disorder, or that the member was stabilized on esketamine during a psychiatric hospitalization.
4. Will the requested agent be used in combination with an oral antidepressant? ☐ Yes ☐ No

**Section VII. Please complete for requests for Aplenzin > 1 unit/day, bupropion XL > 1 unit/day, desvenlafaxine succinate extended-release > 1 unit/day or Fetzima > 1 unit/day.**

Has dose consolidation been attempted? ☐ Yes ☐ No. Please describe medical necessity for quantities above 30 units/month. _____

_____

**Section VIII. Please complete for requests for Zulresso.**

1. Is the member pregnant? ☐ Yes ☐ No. Please document date of delivery. _____
2. Please document date of onset of major depressive episode(s). _____
3. Member's current weight _____ Date _____

**Section IX. 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 _____

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

_____

## Section X. 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

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)

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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. 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.*

_____

_____

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. 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)).

_____

_____

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.

_____

_____

**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.**

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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 _____