



## 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](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 all that apply. Where applicable, the brand name is provided in brackets for reference.)

#### Long-Acting Cerebral Stimulants

- amphetamine extended-release 1.25 mg/mL oral suspension
- amphetamine salts extended-release [Adderall XR] > 2 units/day
- Adhansia XR (methylphenidate extended-release)
- Adzenys XR-ODT (amphetamine extended-release orally disintegrating tablet)
- Cotelpla XR-ODT (methylphenidate extended-release orally disintegrating tablet)
- Daytrana (methylphenidate transdermal)
- dexmethylphenidate extended-release [Focalin XR] > 2 units/day
- Dyanavel XR (amphetamine extended-release 2.5 mg/mL oral suspension)
- Jornay PM (methylphenidate extended-release)
- methylphenidate extended-release [Concerta] > 2 units/day
- methylphenidate extended-release 72 mg tablet
- methylphenidate extended-release [Aptensio XR]
- 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) > 2 units/day

#### Intermediate/Short-Acting Cerebral Stimulants

- amphetamine salts [Adderall] > 3 units/day
- amphetamine sulfate
- dexmethylphenidate [Focalin] > 3 units/day
- dextroamphetamine 5 mg, 10 mg, 15 mg capsule [Dexedrine] > 3 units/day
- dextroamphetamine 2.5 mg, 7.5 mg, 15 mg, 20 mg, 30 mg tablet
- dextroamphetamine 5 mg, 10 mg tablet > 3 units/day
- dextroamphetamine solution > 30 mL/day
- Evekeo ODT (amphetamine sulfate orally disintegrating tablet)
- methylphenidate [Ritalin] > 3 units/day
- methylphenidate chewable tablet > 3 units/day
- methylphenidate oral solution [Methylin oral solution] > 30 mL/day
- methylphenidate sustained-release tablet > 3 units/day

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

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 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.

---

---

---

---

**Section IV. Please complete for Adhansia XR, Cotempla XR-ODT, Daytrana, Jornay PM, methylphenidate extended-release [Aptensio XR, 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

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. 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.*

---

**Section III. Alpha<sub>2</sub> Agonist or Cerebral Stimulant Request for Members < three years of age.**

Please document complete treatment plan (include all alpha<sub>2</sub> 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<sub>2</sub> 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.

---

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