TUFTS Health Plan

705 Mount Auburn Street
Watertown, MA 02472-1508
tuftshealthplan.com

Pediatric Behavioral Health Medication Initiative
Prior Authorization (PA) Request Form

Please fax form to **617.673.0988** or mail to Tufts Health Plan, 705 Mount Auburn Street, Watertown, MA 02472, Attn: Pharmacy Utilization Management Department. ***Complete this form for Tufts Health Together (MassHealth) only.***

Member Information		
Member Last Name:		Member First Name:
Member ID:	DOB:	Gender: ☐Male ☐Female ☐Unknown

Prescriber Information		
Prescriber Last Name:		Prescriber First Name:
Specialty:	Phone #:	Secure Fax #:
NPI #:		DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):		
POC Email (not required):		
Prescriber or Authorized Representative Signature:		
Date:		

Medical Information

1. Is the member currently in an acute care setting?
   - ☐ Yes (Inpatient)
   - ☐ Yes (Community Based Acute Treatment)
   - ☐ Yes (Partial Hospitalization)
   - ☐ No
2. For members who are in an acute care setting, please document outpatient prescriber after discharge.
   - ☐ Prescriber name: _____
   - ☐ Contact information: _____
3. Has the member been hospitalized for a psychiatric condition within the past three months?
   - ☐ Yes. Please document dates of hospitalizations:

     _____

     _____
   - ☐ No
4. Is the member considered a severed risk of harm to self or others?

- ☐ Yes. Please provide details:

  _____

  _____
- ☐ No

5. Please indicate the prescriber's specialty
   - ☐ Psychiatry
   - ☐ Neurology
   - ☐ Other
   - ☐ Specialist consult details (if prescriber submitting request is not a specialist)
     - ☐ Name(s) of specialist(s): _____
     - ☐ Specialty: _____
     - ☐ Date(s) of last visit or consult:_____
     - ☐ Contact information: _____
6. For mid-level practitioners (e.g., nurse practitioners, physician assistants), please provide the name and specialty of collaborating physician: _____
7. Please document member custody status:
   - ☐ Parent/Guardian
   - ☐ Department of Children and Families (DCF)
8. Please document member placement status:
   - ☐ Home with Parent/Guardian
   - ☐ Foster Care
   - ☐ Residential Treatment Facility
   - ☐ Uncertain
   - ☐ Other: _____
9. Please document agency involvement:
   - ☐ Department of Children and Families (DCF)
   - ☐ Department of Mental Health (DMH)
   - ☐ Department of Developmental Services (DDS)
   - ☐ Department of Youth Services (DYS)
10. Is the member currently receiving appropriate psychotherapeutic and/or community-based services for the targeted clinical mental health concerns (e.g., Applied Behavioral Analysis, Children's Behavioral Health Initiative, school interventions, specialized placement)?
    - ☐ Yes. Please document details of intervention, if applicable:

      _____

      _____
    - ☐ No
11. Psychiatric care provided is coordinated with other psychotherapeutic and community-based services.
    - ☐ Yes
    - ☐ No
12. Is this member a referral candidate for care coordination?
    - ☐ Yes
    - ☐ No
13. If the answer to number 12 is "yes", please describe which additional behavioral health services would be beneficial.

    _____

    _____

14. Please provide the member's complete treatment regimen (including all current and requested behavioral health medications). Include each medication's name, dose, frequency, and indication.

Medication name/dose/frequency	Indication
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.

POLYPHARMACY

Antidepressant Polypharmacy

Complete this section for all members less than 18 years of age if the request will result in antidepressant polypharmacy (overlapping pharmacy claims for two or more antidepressants for at least 60 days within a 90 day period).

15. For antidepressant polypharmacy, please indicate whether one of the following applies:
    - ☐ Member is cross titrating/tapering antidepressant therapy
    - ☐ Member had an inadequate response (defined as four weeks of therapy) or adverse reaction to two monotherapy trials as clinically appropriate
    - ☐ Antidepressant polypharmacy regimen of two or fewer antidepressants includes one of the following agents: bupropion, mirtazapine, or trazodone
    - ☐ One antidepressant in the regimen is indicated for a comorbid condition in which antidepressants may be clinically appropriate
16. Please document if monotherapy trials (include drug name, dates/duration of use, and outcome) were tried before prescribing polypharmacy with two or more antidepressants for this member.

    _____
    _____
    _____
17. Please document clinical rationale for antidepressant polypharmacy for this member.

    _____
    _____
    _____
18. 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.

    _____
    _____
    _____

Benzodiazepine Polypharmacy

Complete this section for all members less than 18 years of age if the request will result in benzodiazepine polypharmacy (overlapping pharmacy claims for two or more benzodiazepines for at least 60 days within a 90 day period).

19. Does the member have a seizure diagnosis only?
    - ☐ Yes
    - ☐ No
20. Is the member cross-titrating/tapering benzodiazepine therapy?
    - ☐ Yes
    - ☐ No
21. Please document if monotherapy trials (include drug name, dates/duration of use, and outcome) were tried before prescribing polypharmacy with two or more benzodiazepines for this member.

    _____
    _____
    _____
22. Please document clinical rationale for benzodiazepine polypharmacy for this member.

    _____
    _____
    _____
23. 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.

    _____
    _____
    _____

Cerebral Stimulant Polypharmacy

Complete this section for all members less than 18 years of age if the request will result in cerebral stimulant polypharmacy (overlapping pharmacy claims for two or more cerebral stimulants for at least 60 days within a 90 day period; immediate-release and extended-release formulations of the same chemical entity are counted as one).

24. For **cerebral stimulant polypharmacy**, please select all that apply:
    - ☐ Member had an inadequate response (defined as more than 7 days of therapy), adverse reaction or contraindication to monotherapy trial with a methylphenidate product
    - ☐ Member had an inadequate response (defined as more than 7 days of therapy), adverse reaction or contraindication to monotherapy trial with an amphetamine product
25. Please document any additional monotherapy trials (include drug name, dates/duration of use, and outcome) that were tried before prescribing polypharmacy with two or more cerebral stimulants for this member.

    _____
    _____
    _____
26. Please document clinical rationale for cerebral stimulant polypharmacy for this member.

    _____
    _____
    _____

27. 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.

_____
_____
_____

Mood Stabilizer Polypharmacy

Complete this section for all members less than 18 years of age if the request will result in mood stabilizer polypharmacy (overlapping pharmacy claims for three or more mood stabilizers for at least 60 days within a 90 day period).

28. Does the member have a seizure diagnosis only?
    - ☐ Yes
    - ☐ No
29. Please select all that apply:
    - ☐ Member has a diagnosis for which mood stabilizers may be clinically appropriate (e.g., migraine, neuropathic pain)
    - ☐ Member has tried and failed other clinically appropriate therapies
    - ☐ Member is cross-titrating or tapering mood stabilizers therapy
    - ☐ Member has had an inadequate response or adverse reaction to two monotherapy trials and/or combination therapy trials as clinically appropriate
30. Please document if monotherapy trials (include drug name, dates/duration of use, and outcome) were tried before prescribing polypharmacy with three or more mood stabilizers.

_____
_____
_____

31. Please document clinical rationale for mood stabilizer polypharmacy.

_____
_____
_____

32. 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.

_____
_____
_____

Antipsychotic Polypharmacy

Complete this section for all members less than 18 years of age if the request will result in antipsychotic polypharmacy (overlapping pharmacy claims for two or more antipsychotics for at least 60 days within a 90 day period).

33. Does the member have a comprehensive behavioral health plan (i.e., non-pharmacologic interventions) in place?
    - ☐ Yes
    - ☐ No
34. Please select the stage of treatment and clinical rationale for antipsychotic polypharmacy.
    - ☐ **Acute Stage** (defined as 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.

Medication Name/Dose/Frequency	Dates/Duration of Use
1.	1.
2.	2.

☐ Member is transitioning from one antipsychotic to the other.

☐ Other, please explain:

_____

_____

_____

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

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

☐Yes

☐No

☐ Has the member been on the requested regimen for 12 months or longer?

☐ Yes. Please select all options below that apply to this member:

☐ 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); select all that apply:

☐ Member is transitioning from one antipsychotic to another

☐ Member is tapering antipsychotic. Please describe antipsychotic therapy discontinuation. Please explain:

_____

_____

_____

Multiple Behavioral Health Medications

Complete this section for members less than 18 years of age if the request will result in prescriptions of four or more behavioral health medications within a 45 day period.

35. Please document monotherapy trials (include drug name, dates/duration of use, and outcome) tried before prescribing a polypharmacy regimen for this member.

Medication Name	Dates/Duration of Use	Outcomes
1.	1.	1.
2.	2.	2.

3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.

36. Does the member have a seizure diagnosis only?
    - ☐ Yes
    - ☐ No
37. Please select all that apply:
    - ☐ Member is cross-titrating or tapering mood stabilizer
    - ☐ Member has had an inadequate response or adverse reaction to two monotherapy trials and/or multiple combination trials as clinically appropriate
    - ☐ Member has a diagnosis in which mood stabilizers may be clinically appropriate (e.g., migraine, neuropathic pain) and documentation that other clinically appropriate therapies have been tried and failed
    - ☐ Member has a psychiatric and comorbid diagnosis in which mood stabilizers may be clinically appropriate (e.g., migraine, neuropathic pain) and documentation that other clinically relevant therapies have been tried and failed.
38. Please document the clinical rationale for use of multiple behavioral health medications for this member who is less than 18 years of age.

    _____
    _____
    _____

39. 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.

    _____
    _____
    _____

AGE LIMIT

Request for One of the Following Classes of Medications for Members Less than 6 Years of Age: Antidepressant, Atomoxetine, Benzodiazepine, Buspirone, or Mood Stabilizer

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

Medication Name	Dates/Duration of Use	Outcomes
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.

40. Please document the clinical rationale for use of an antidepressant, atomoxetine, benzodiazepine, buspirone, or mood stabilizer for this member who is less than 6 years old.

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    _____

    _____

Request for an Antipsychotic for Members Less Than 6 Years of Age

41. Does the member have a comprehensive behavioral treatment plan (i.e., non-pharmacological intervention) in place?
    - ☐ Yes
    - ☐ No

42. 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)
    - ☐ **Maintenance Stage** (response to antipsychotic treatment with goal of remission or recovery)
        - ☐ Is the regimen effective, therapy benefits outweigh risks, and appropriate monitoring is in place?
          ☐Yes ☐No
        - ☐ Has the member been on the requested regimen for 12 months or longer?
          ☐ 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:

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_____
_____

☐ No

☐ **Discontinuation Stage** (clinically indicated that the antipsychotic regimen can likely be successfully tapered)
☐ Member is transitioning from one antipsychotic to another
☐ Member is tapering antipsychotic. Please describe taper plan, including duration.

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Request for an Alpha$_2$ Agonist or Cerebral Stimulant for Members Less than 3 years of Age

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

Medication Name	Dates/Duration of Use	Outcomes
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.
5.	5.	5.
6.	6.	6.
7.	7.	7.

44. Does the member have a cardiovascular diagnosis only?
☐ Yes
☐ No

45. Please document clinical rationale for use of an alpha$_2$ agonist and/or cerebral stimulant for this member who is less than three years of age.

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_____
_____

Request for a Hypnotic Medication for Members Less than 6 Years of Age

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

_____
_____
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47. Please document medication trials with melatonin and/or clonidine, if clinically appropriate. Include drug name, dates/duration of use, and outcome.

Medication Name	Dates/Duration of Use	Outcomes
1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.

48. Please document the clinical rationale for the use of a hypnotic agent for this member who is less than 6 years of age.

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