Pediatric Behavioral Health Medication Initiative
Effective 10/01/2022

Plan	☒ MassHealth ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

Pediatric Behavioral Health Medication Initiative (PBHMI) requires prior authorization for pediatric members (generally members less than 18 years of age) for certain behavioral health medication classes and/or specific medication combinations (i.e., polypharmacy) that have limited evidence for safety and efficacy in the pediatric population.

Prior authorization is required for members less than 18 years old for the following situations:

- Behavioral health medication polypharmacy: pharmacy claims for 4 or more behavioral health medications (i.e., alpha$_2$ agonists, antidepressants, antipsychotics, armodafinil, atomoxetine, benzodiazepines, buspirone, cerebral stimulants, donepezil, hypnotics, memantine, modafinil, naltrexone, viloxazine and mood stabilizers) filled within a 45-day period
- Antipsychotic polypharmacy: overlapping pharmacy claims for 2 or more antipsychotics (includes first-generation and/or second-generation antipsychotics, except short-acting injectable formulations) for ≥ 60 days within a 90-day period
- Antidepressant polypharmacy: overlapping pharmacy claims for 2 or more antidepressants for ≥ 60 days within a 90-day period
- Cerebral stimulant polypharmacy: overlapping pharmacy claims for 2 or more cerebral stimulants (immediate-release and extended-release formulations of the same chemical entity are counted as one) for ≥ 60 days within a 90-day period
- Mood stabilizer polypharmacy: overlapping pharmacy claims for 3 or more mood stabilizers for ≥ 60 days within a 90-day period
- Benzodiazepine polypharmacy: overlapping pharmacy claims for 2 or more benzodiazepines (hypnotic benzodiazepine agents, clobazam, nasal and rectal diazepam, nasal midazolam, and injectable formulations are NOT included) for ≥ 60 days within a 90-day period

- Any pharmacy claims for an antidepressant, armodafinil, buspirone, donepezil, memantine, modafinil or naltrexone for members less than 6 years old
- Any pharmacy claims for an antipsychotic for members less than 6 years old
- Any pharmacy claims for atomoxetine and viloxazine for members less than 6 years old
- Any pharmacy claims for a hypnotic or hypnotic benzodiazepine or Mood Stabilizer (excluding anticonvulsants indicated for seizure) for members less than 6 years old
- Any pharmacy claims for an alpha$_2$ agonist or cerebral stimulant for members less than 3 years old

Pediatric Behavioral Health Medication Initiative Medication List[1]			
Antidepressants		**Mood Stabilizers**	
amitriptyline	maprotiline	carbamazepine	lithium
amoxapine	mirtazapine	divalproex	oxcarbazepine
bupropion	nefazodone	eslicarbazepine	pregabalin
citalopram	nortriptyline	gabapentin	topiramate
clomipramine	paroxetine	lamotrigine	valproic acid
desipramine	phenelzine	**Antianxiety Agents**	
desvenlafaxine	protriptyline	alprazolam	diazepam[3]
doxepin	selegiline[2]	buspirone	lorazepam
duloxetine	sertraline	chlordiazepoxide	meprobamate
escitalopram	tranylcypromine	chlordiazepoxide/ amitriptyline	midazolam[3]
esketamine	trazodone	clonazepam	oxazepam
fluoxetine	trimipramine	clorazepate	
fluvoxamine	venlafaxine	**Hypnotics**	
imipramine	vilazodone	daridorexant	quazepam
isocarboxazid	vortioxetine	doxepin[4]	suvorexant
levomilnacipran		estazolam	temazepam
Antipsychotics		eszopiclone	triazolam
aripiprazole	olanzapine	flurazepam	zaleplon
asenapine	olanzapine/fluoxetine	lemborexant	zolpidem
brexpiprazole	olanzapine/samidorphan	**Alpha$_2$ Agonists**	
cariprazine	paliperidone	clonidine	guanfacine
chlorpromazine	perphenazine	**Stimulants**	
clozapine	perphenazine/amitriptyline	amphetamine	lisdexamfetamine
fluphenazine	pimozide	amphetamine sulfate	methamphetamine
haloperidol	quetiapine	dexmethylphenidate	methylphenidate
iloperidone	risperidone	dextroamphetamine	serdexmethylphenidate/ dexmethylphenidate
loxapine	thioridazine	dextroamphetamine/ amphetamine	
lumateperone	thiothixene	**Miscellaneous**	
lurasidone	trifluoperazine	armodafinil	modafinil
molindone	ziprasidone	atomoxetine	naltrexone[5]
		donepezil	viloxazine
		memantine	

[1] Short-acting intramuscular injectable and intravenous formulations are not included.

[2] Emsam® (selegiline) is the only selegiline formulation included.
[3] Nasal and rectal diazepam and nasal midazolam formulations are not included.
[4] Doxepin tablet is classified as a hypnotic agent and not included in the antidepressant restrictions.
[5] Injectable naltrexone (Vivitrol) is not included.

Coverage Guidelines

For all requests, individual drug PA must be met first where applicable.

Behavioral health medication polypharmacy:
Prescriber provides documentation of **ONE** of the following:

1. Member had a recent psychiatric hospitalization (within the last three months) **OR** member has a history of severe risk of harm to self or others.

OR

2. Member is using naltrexone for substance use disorder

OR

3. **ALL** of the following:
    a. Multiple and/or treatment-resistant behavioral health and other non-behavioral health diagnoses where use may be clinically appropriate (e.g., migraines [TCAs, venlafaxine], neuropathic pain [duloxetine, TCAs, venlafaxine], refractory enuresis [imipramine], hypertension [alpha agonists])
    b. Treatment plan including names of current behavioral health medications and corresponding diagnoses
    c. Prescriber is a specialist (e.g., psychiatrist, neurologist) or consult was provided
    d. For regimens including **>1 mood stabilizer**, then **ONE** of the following:
        i. Member has a **seizure diagnosis only**
        ii. **Member has a psychiatric diagnosis, with or without seizure diagnosis, and ONE of the following**:
            1. Cross-titration/taper of mood stabilizer therapy
            2. Inadequate response or adverse reaction to two monotherapy and/or multiple combination therapy trials as clinically appropriate
        iii. **Member has a diagnosis in which mood stabilizers may be clinically appropriate (e.g., migraine, neuropathic pain), with or without seizure diagnosis**, other clinically relevant therapies for the diagnosis (migraine and/or neuropathic pain) have been tried and failed; therefore, multiple mood stabilizers are needed to treat the member's condition
        iv. **Member has a psychiatric diagnosis AND a diagnosis in which mood stabilizers may be clinically appropriate (e.g., migraine, neuropathic pain), with or without seizure diagnosis, BOTH of the following***:
            1. ONE of the following:
                a. Cross-titration/taper of mood stabilizer
                b. Inadequate response or adverse reaction to two monotherapy and/or multiple combination therapy trials as clinically appropriate
            2. Other clinically relevant therapies for the diagnosis (migraine and/or neuropathic pain) have been tried and failed; therefore, multiple mood stabilizers are needed to treat the member's condition

**Members with a seizure diagnosis AND a psychiatric diagnosis AND a diagnosis in which mood stabilizers may be clinically appropriate (e.g., migraine, neuropathic pain) may get up to three mood stabilizers before meeting this additional criteria*.

Antipsychotic polypharmacy:

Prescriber provides documentation of **ONE** of the following:

1. Member had a recent psychiatric hospitalization (within the last three months) **OR** member has a history of severe risk of harm to self or others.

OR

2. Documentation of **ALL** of the following:
    a. Appropriate diagnosis
    b. Treatment plan including names of current antipsychotics, dose and frequency, and corresponding diagnoses
    c. Documentation that a comprehensive behavioral health plan (i.e. non-pharmacologic interventions) is in place
    d. Prescriber is a psychiatrist or psychiatry consult was provided
    e. Documentation of **ONE** of the following stages of treatment:
        i. **Acute**: initiation of antipsychotic treatment likely with subsequent dose adjustments to maximize response and minimize side effects. Documentation of **ONE** of the following is required:
            a. Cross-titration/taper of antipsychotic therapy
            b. Inadequate response or adverse reaction to two monotherapy trials as clinically appropriate
        ii. **Maintenance**: response to antipsychotic treatment with goal of remission or recovery. If member has been on the antipsychotic regimen for the past 12 months, documentation of **ONE** of the following is required:
            a. Previous efforts to reduce/simplify the antipsychotic regimen in the past 24 months resulted in symptom exacerbation
            b. Family/caregiver does not support the antipsychotic regimen change at this time due to risk of exacerbation
            c. Other significant barrier for antipsychotic therapy discontinuation
        i. **Discontinuation**: clinically indicated that the antipsychotic regimen can likely be successfully tapered. Documentation of cross-titration or taper of antipsychotic therapy is required.

Antidepressant polypharmacy:

Prescriber provides documentation of **ONE** of the following:

1. Member had a recent psychiatric hospitalization (within the last three months) **OR** member has a history of severe risk of harm to self or others.

OR

2. Documentation of **ALL** of the following:
    a. Psychiatric diagnoses including treatment-resistant conditions
    b. Treatment plan including names of current antidepressants and corresponding diagnoses
    c. Prescriber is a psychiatrist or consult was provided
    d. **ONE** of the following:
        i. Cross-titration/taper of antidepressant therapy

ii. Inadequate response (defined as four weeks of therapy) or adverse reaction to two monotherapy trials as clinically appropriate
iii. Antidepressant polypharmacy regimen of ≤ two antidepressants includes ONE of the following: bupropion, mirtazapine or trazodone
iv. One antidepressant in the regimen is indicated for a comorbid condition (e.g., migraines [TCAs, venlafaxine], neuropathic pain [duloxetine, TCAs, venlafaxine], obsessive compulsive disorder [clomipramine], refractory enuresis [imipramine])

Cerebral stimulant polypharmacy:
Prescriber provides documentation of **ONE** of the following:

1. Member had a recent psychiatric hospitalization (within the last three months) **OR** member has a history of severe risk of harm to self or others.

OR

2. Documentation of **ALL** of the following is required:
    a. Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) or hyperactivity associated with Autism Spectrum Disorder (ASD)
    b. Treatment plan including names of current cerebral stimulants and corresponding diagnoses
    c. **ALL** of the following:
        i. Inadequate response (defined as >7 days of therapy), adverse reaction or contraindication to monotherapy trials with BOTH methylphenidate **and** amphetamine
        ii. Clinical rationale for use of a methylphenidate agent in combination with an amphetamine agent

Mood stabilizer polypharmacy*:
Prescriber provides documentation of **ONE** of the following:

1. Member had a recent psychiatric hospitalization (within the last three months) **OR** member has a history of severe risk of harm to self or others.

OR

2. Member has a seizure diagnosis ONLY

OR

3. **ONE** of the following:
    a. Member has a psychiatric diagnoses, with or without a seizure diagnosis, and meets **ALL** of the following:
        i. Treatment plan including names of current mood stabilizers and corresponding diagnoses
        ii. Prescriber is a specialist (e.g., psychiatrist, neurologist) or consult was provided
        iii. **ONE** of the following:
            1. Cross-titration/taper of mood stabilizer therapy
            2. Inadequate response or adverse reaction to two monotherapy trials and/or multiple combination therapy trials as clinically appropriate
    b. Member has a diagnosis in which mood stabilizers may be clinically appropriate (e.g., migraine, neuropathic pain), with or without a seizure diagnosis, and meets **BOTH** of following:
        i. Treatment plan including names of current mood stabilizers and corresponding diagnoses

ii. Physician documentation that other clinically relevant therapies for the diagnosis have been tried and failed; therefore, multiple mood stabilizers are needed to treat the member's condition

c. Member has a psychiatric diagnosis **AND** a comorbid diagnosis in which mood stabilizers may be clinically appropriate (e.g., migraine, neuropathic pain), with or without seizure diagnosis, **AND** meets the ALL of the following:
   i. Treatment plan including names of current mood stabilizers and corresponding diagnoses
   ii. Prescriber is a specialist (e.g., psychiatrist, neurologist) or consult was provided
   iii. Physician documentation that other clinically relevant therapies for the diagnosis have been tried and failed; therefore, multiple mood stabilizers are needed to treat the member's condition
   iv. **ONE** of the following:
      1. Cross-titration/taper of mood stabilizer therapy
      2. Inadequate response or adverse reaction to two monotherapy trials and/or multiple combination therapy trials as clinically appropriate

**If a member has a seizure diagnosis, multiple mood stabilizers will be approved without meeting any additional criteria.*

Benzodiazepine polypharmacy:
Prescriber provided documentation of **ONE** of the following:

1. Member had a recent psychiatric hospitalization (within the last three months) **OR** member has a history of severe risk of harm to self or others.

OR

2. Member has a seizure diagnosis ONLY

OR

3. Documentation of **ALL** of the following:
   a. Clinically appropriate diagnoses (e.g., anxiety, panic disorder, insomnia, agitation, skeletal muscle pain)
   b. Treatment plan including names of current benzodiazepines and corresponding diagnoses
   c. **ONE** of the following:
      i. Cross-titration/taper of benzodiazepine therapy
      ii. Compelling rationale for use of ≥ 2 benzodiazepines of different chemical entities (e.g., lorazepam and clonazepam)

Age Limits

Members < 6 years old:

Excluding anticonvulsants indicated for seizure only

Antidepressant, armodafinil, benzodiazepine, buspirone, donepezil, memantine, modafinil, mood stabilizer, or naltrexone:
Prescriber provides documentation of **ONE** of the following:

1. Member had a recent psychiatric hospitalization (within the last three months) **OR** member has a history of severe risk of harm to self or others.

OR

2. Requests for anticonvulsant and/or benzodiazepine, member has a seizure diagnosis ONLY

OR

3. Member has a psychiatric diagnosis, **ALL** of the following criteria must be met:
    a. Treatment plan including names of current behavioral health medications and corresponding diagnoses
    b. Prescriber is a specialist (e.g., psychiatrist, neurologist) or consult was provided.

OR

4. Member has a diagnosis in which an antidepressant or a mood stabilizer may be clinically appropriate (e.g., migraine, neuropathic pain), **ALL** of the following criteria for the requested antidepressant or mood stabilizer must be met:
    a. Treatment plan including names of current behavioral health medications and corresponding diagnoses
    b. Prescriber is a specialist (e.g., psychiatrist, neurologist) or consult was provided

OR

5. If the member has multiple comorbid conditions, then the member must meet the criteria outlined above (#1-4) depending on the diagnosis, as applicable

Strattera (atomoxetine®) or Qelbree® (viloxazine)

Prescriber provides documentation of **ONE** of the following:

1. Member had a recent psychiatric hospitalization (within the last three months) **OR** member has a history of severe risk of harm to self or others.

OR

2. Documentation of **ALL** of the following:
    a. Diagnosis of ADHD
    b. Treatment plan including names of current behavioral health medications and corresponding diagnoses
    c. **If the member is <3 years of age**, prescriber is a psychiatrist or psychiatry consult was provided

Antipsychotics

Prescriber provides documentation of **ONE** of the following:

1. Member had a recent psychiatric hospitalization (within the last three months) **OR** member has a history of severe risk of harm to self or others.

OR

2. For new start therapy requests**, ALL** of the following is required:
    a. Complete medication treatment plan including name, dose and frequency of all current behavioral health medications, associated target symptoms, and behavioral health diagnoses
    b. Comprehensive behavioral health treatment plan (i.e., non-pharmacological interventions) is in place
    c. Member is in the **acute stage** of treatment which is defined as the initiation of antipsychotic treatment with likely subsequent dose adjustments to maximize response and minimize side effects
    d. Prescriber is a specialist in one of the following areas or a consult from a specialist was provided: child psychiatry, pediatric neurology, or developmental/behavioral pediatrics

OR

3. For continuation of therapy requests, **ALL** of the following is required:
    a. Complete medication treatment plan including name, dose and frequency of call current behavioral health medications, associated target symptoms, and behavioral health diagnoses

b. Comprehensive behavioral health treatment plan (i.e., non-pharmacological interventions) is in place
c. Prescriber is a specialist in one of the following areas or a consult from a specialist was provided: child psychiatry, pediatric neurology, or developmental/behavioral pediatrics
d. **ONE** of the following stages of treatment:
    i. Maintenance: response to antipsychotic treatment with goal of remission or recovery
    ii. Discontinuation: clinically indicated that the antipsychotic can likely be tapered successfully
e. **If maintenance stage**, regimen is effective, therapy benefits outweigh risks, and appropriate monitoring is in place
f. **If the member has been on the antipsychotic regimen for the past 12 months**, need clinical rationale for extended therapy to include at least **ONE** of the following:
    i. Previous efforts to reduce/simplify the antipsychotic regimen in the past 12 months resulted in symptom exacerbation
    ii. Family/caregiver does not support antipsychotic regimen change at this time due to risk of exacerbation
    iii. Other significant barrier for antipsychotic therapy discontinuation
g. **If discontinuation stage**, cross-titration or taper of antipsychotic therapy

Hypnotic or Hypnotic Benzodiazepine
Prescriber provides documentation of **ALL** of the following:

1. Member meets all criteria for the requested agent as specified in the Hypnotic Agents guideline, if applicable.
2. Treatment plan including name of current hypnotic agent and corresponding diagnosis
3. Prescriber is a specialist (e.g., psychiatrist, neurologist) or consult was provided
4. **ONE** of the following†:
    a. Diagnosis of **insomnia along *with* other behavioral health comorbidities except ADHD** (e.g., anxiety disorders, depression)
    b. For diagnosis of **insomnia *without* behavioral health comorbidities**, paid claims or physician documentation of inadequate response (defined by ≥10 days of therapy), adverse reaction, or contraindication to melatonin *(examples of contraindication: autoimmune disorder such as Addison's disease, Crohn's disease, Cushing's disease, Graves' disease)*
    c. For diagnosis of **insomnia *with concomitant* ADHD**, paid claims or physician documentation of inadequate response (defined by ≥10 days of therapy), adverse reaction, or contraindication to melatonin AND clonidine *(examples of contraindication for clonidine: depression, cardiovascular disease, coronary insufficiency, renal impairment, sinus node dysfunction, conduction disturbances, or history of bradycardia)*

†This only applies to members < 6 requesting Ambien (zolpidem), Ambien CR (zolpidem extended-release tablet)*, estazolam, flurazepam, Halcion (triazolam)*, Lunesta (eszopiclone)*, Restoril (temazepam)* 7.5 mg, 15 mg and 30 mg and Sonata (zaleplon)**
**Both brand and generic require PA*

Members < 3 years old:

Alpha$_2$ agonist or cerebral stimulant

Prescriber provides documentation of **ONE** of the following:

1. Member had a recent psychiatric hospitalization (within the last three months) **OR** member has a history of severe risk of harm to self or others.

OR

2. Member had a cardiovascular diagnosis ONLY

OR

3. Documentation of **ALL** of the following:
    a. Diagnosis of ADHD, hyperactivity associated with ASD, or developmental/intellectual disability
    b. Treatment including name(s) of current alpha$_2$ agonist(s) or cerebral stimulant(s) and corresponding diagnoses
    c. Compelling clinical rationale for alpha$_2$ agonist use in a member <3 years of age

Limitations

1. Initial approvals and reauthorizations will be granted for 12 months.
2. This program is used in conjunction with current prior authorization, step therapy or quantity limit restrictions.

Appendix

Table I: List of mood stabilizers separated by clinical indications for seizure alone, behavioral health alone, and concomitant use for seizure and behavioral health indications

Behavioral Health Indications	Behavioral Health and Seizure Indications	Seizure Indications Only (Excluded from all PBHMI restrictions)
Lithobid® (**lithium**)	Tegretol®, Tegretol® XR, Carbatrol® ER, Epitol®, Equetro® , (**carbamazepine**)	Briviact® (**brivaracetam**)
		Epidiolex® (**cannabidiol**)
	Aptiom® (**eslicarbazepine**)	Xcopri® (**cenobamate**)
	Neurontin®, Horizant®, Gralise® (**gabapentin**)	Onfi® tablets and suspension Sympazan® film (**clobazam**)
	Lamictal®, Lamictal® CD , Lamictal® ODT, Lamictal® ODT Starter Kit, Lamictal® XR, Lamictal® XR Starter Kit, Lamictal® Starter Kit (**lamotrigine**)	Zarontin® (**ethosuximide**)
	Trileptal®, Oxtellar XR® (**oxcarbazepine**)	Felbatol® (**felbamate**)
	Lyrica®, Lyrica CR® (**pregabalin**)	
	Eprontia®, Topamax®, Topamax® Sprinkle, Trokendi XR® (**topiramate**)	Fintepla® (**fenfluramine**)
		Vimpat® (**lacosamide**) solution, tablets, injection

	Depakene®, Depakote®, Depakote® ER, Depakote® Sprinkle (**valproic acid**)	Elepsia XR®, Keppra®, Spritam®(**levetiracetam**)
		Celontin® (**methsuximide**)
		Fycompa® (**perampanel**)
		Dilantin®, Dilantin-125®, Dilantin Infatab (**phenytoin**), phenytoin 100 mg/4 mL unit dose suspension, Phenytek® (**phenytoin sodium**), phenytoin injection
		Mysoline® (**primidone**)
		Banzel® (**rufinamide**) tablets and suspension
		Diacomit® (stiripentol)
		Gabitril®(**tiagabine**)
		Sabril® (**vigabatrin**)
		Zonegran® (**zonisamide**)

CD=chewable dispersible, ER=extended release, ODT= oral disintegrating tablet, XR=extended release

References

N/A

Review History

07/01/17 – Reviewed
06/25/18 – Reviewed
09/26/18 – Updated
06/19/19 – Reviewed
05/18/2022 – Reviewed and Updated for May P&T. All categories were updated to unify with MH UPPL
09/21/2022 – Reviewed and Updated for Sept P&T. All categories clarified to unify with MH UPPL. Appendix reference table I was added (exclusion of Elepsia XR from PBHMI due to seizure only). Addition of naltrexone powder was included. New drug Quviviq (daridorexant) was added. Effective 10.1.2022

Disclaimer

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