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**Section 3.15**      **Psychotropic Medication: Prescribing and Monitoring**

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**3.15.1      Introduction**

The use of psychotropic medications is often an integral part of treatment for persons receiving care for behavioral health conditions. As such, the use of psychotropic medications must be monitored closely to help ensure that persons are treated safely and effectively. ADHS/DBHS developed guidelines and minimum requirements designed to:

- Ensure the safety of persons taking psychotropic medications;
- Reduce or prevent the occurrence of adverse side effects; and
- Help persons who are taking psychotropic medications restore and maintain optimal levels of functioning and achieve positive clinical outcomes.

**3.15.2      References**

The following citations can serve as additional resources for this content area:

[42 C.F.R. § 438.100](#)

[A.R.S. § 32-1901](#)

[R9-20-101](#)

[R9-20-303](#)

[R9-21-206.01](#)

[R9-21-207](#)

[Section 3.2, Appointment Standards and Timeliness of Service](#)

[Section 3.11, General and Informed Consent to Treatment](#)

[Section 3.16, Medication Formulary](#)

[Section 3.20, Credentialing and Privileging](#)

[Section 4.2, Behavioral Health Medical Record Standards](#)

[Section 4.3, Coordination of Care With AHCCCS Health Plans, Primary Care Providers, and Medicare Providers](#)

[Section 7.4, Reporting of Incidents, Accidents and Deaths](#)

[Informed Consent for Psychotropic Medication Treatment Practice Protocol](#)

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[Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation Practice Protocol](#)

[Psychotropic Medication Use in Children, Adolescents, and Young Adults Clinical Practice Protocol](#)

[General and Informed Consent to Treatment for Persons Under the Age of 18 Policy Clarification Memorandum](#)

[The Arizona Medical Board's Guidelines For Physicians Who Incorporate Or Use Complementary Or Alternative Medicine In Their Practice](#)

[National Coordinating Council for Medication Error Reporting and Prevention](#)

#### 3.15.3 Scope

To whom does this apply?

All T/RBHA and subcontracted providers including the Arizona State Hospital utilizing behavioral health medical practitioners to prescribe psychotropic medications to the following populations:

- All Title XIX/XXI eligible persons;
- All non-Title XIX/XXI persons determined to have a Serious Mental Illness; and
- All other persons, based on available funding.

#### 3.15.4 Did you know...?

- A person's target symptoms and clinical responses to treatment must be identified for each medication prescribed and documented in the person's comprehensive clinical record. Also, the use of psychotropic medication must always be referenced and incorporated into the person's individual treatment plan.
- Education regarding all prescribed medications must be routinely provided to persons, family members, guardians, or designated representatives in a culturally competent, language appropriate manner.
- Psychotropic medications that are not clinically effective after reasonable trials should be discontinued, unless the rationale for continuation can be supported and is documented in the person's comprehensive clinical record.
- Behavioral health medical practitioners must coordinate with primary care providers (PCPs) or other health care providers to minimize the potential for adverse clinical outcomes when prescribing psychotropic medications. See [Section 4.3, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers](#) regarding expectations for coordination of care with PCPs and other health care providers.

#### 3.15.5 Definitions

[Adverse Drug Event \(ADE\)](#)

[Adverse Drug Reaction \(ADR\)](#)

[Behavioral Health Medical Practitioner](#)

[Complementary and Alternative Medicine \(CAM\)](#)

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#### [Cross-tapering](#)

#### [Medication Error](#)

##### **3.15.6 Objectives**

To ensure that psychotropic medications prescribed for persons are prescribed and monitored in a manner that provides for safe and effective use.

To ensure that medication will not be used as punishment, for the convenience of the staff, or as a substitute for other behavioral health services and will be given in the least amount medically necessary with particular emphasis placed on minimizing side effects which otherwise would interfere with aspects of treatment, as stated in [R9-21-207\(C\)](#).

##### **3.15.7 Procedures**

###### **3.15.7-A. Basic requirements**

Medications may only be prescribed by T/RBHA credentialed and licensed physicians, licensed physician assistants, or licensed nurse practitioners. See [Section 3.20, Credentialing and Privileging](#) for more information regarding credentialing requirements.

Psychotropic medication will be prescribed by a psychiatrist who is a licensed physician, or a licensed nurse practitioner, licensed physician assistant, or physician trained or experienced in the use of psychotropic medication, who has seen the client and is familiar with the client's medical history or, in an emergency, is at least familiar with the client's medical history.

When a client on psychotropic medication receives a yearly physical examination, the results of the examination will be reviewed by the physician prescribing the medication. The physician will note any adverse effects of the continued use of the prescribed psychotropic medication in the client's record (See [Section 4.2, Behavioral Health Medical Record Standards](#)).

Whenever a prescription for medication is written or changed, a notation of the medication, dosage, frequency or administration, and the reason why the medication was ordered or changed will be entered in the client's record (See [Section 4.2, Behavioral Health Medical Record Standards](#)).

###### **3.15.7-B. Assessments**

Reasonable clinical judgment, supported by available assessment information, must guide the prescription of psychotropic medications. To the extent possible, candidates for psychotropic medications must be assessed prior to prescribing and providing psychotropic medications. Psychotropic medication assessments must be documented in the person's comprehensive clinical record per [Section 4.2, Behavioral Health Medical Record Standards](#) and must be scheduled in a timely manner consistent with [Section 3.2, Appointment Standards and Timeliness of Service](#). Behavioral health medical practitioners can use assessment information that has already been collected by other sources and are not required to document existing assessment information that is part of the person's comprehensive clinical record. At a minimum, assessments for psychotropic medications must include:

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- An adequately detailed medical and behavioral health history;
- A mental status examination;
- A diagnosis;
- Target Symptoms;
- A review of possible medication allergies;
- A review of previously and currently prescribed medications including any noted side effects and/or potential drug-drug interactions;
- For sexually active females of childbearing age, a review of reproductive status (pregnancy); and
- For post-partum females, a review of breastfeeding status.

Reassessments must ensure that the provider prescribing psychotropic medication notes in the client's record (See [Section 4.2, Behavioral Health Medical Record Standards](#)):

- The appropriateness of the current dosage;
- All medication being taken and the appropriateness of the mixture of the medications;
- Any side effects, abnormal and/or involuntary movements if treated with an anti-psychotic medication; and
- The reason for the use of the medication and the effectiveness of the medication.

#### **3.15.7-C. Informed consent**

Informed consent must be obtained from the person and/or legal guardian for each psychotropic medication prescribed. When obtaining informed consent, the behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience must communicate in a manner that the person and/or legal guardian can understand and comprehend. The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent (See [Section 4.2, Behavioral Health Medical Record Standards](#)). Essential elements for obtaining informed consent for medication are contained within [PM Form 3.15.1, Informed Consent for Psychotropic Medication Treatment](#). **It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which this is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.**

The use of [PM Form 3.15.1](#) is recommended as a tool to document informed consent for psychotropic medications. If [PM Form 3.15.1](#) is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the person's individual comprehensive clinical record in an alternative fashion (See [Section 4.2, Behavioral Health Medical Record Standards](#)).

**Children Birth to Five Years** -- As per DBHS Practice Protocol: [Psychiatric Best Practice Guidelines for Children: Birth to Five Years of Age](#), the behavioral health medical practitioner shall document in the child's clinical record the rationale for medication choice and the provision of informed consent to parents/caregivers/guardians which must contain the elements outlined in this protocol. NARBHA has developed [PM Form 3.15.3 Informed Consent for Children Under Five Years Old Psychotropic Medication Treatment](#) (NARBHA Suggested Format) to assist in documenting all the required elements.

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**Psychiatric Services Over Telemedicine** -- Prior to the delivery of psychiatric services over telemedicine/ video conferencing, the behavioral health medical practitioner must have documentation of telemedicine orientation/training as per Section 10.10 Telemedicine Clinical Services. Evidence of the orientation is placed in the personnel record of the telemedicine health care provider. NARBHA Telemedicine staff is available to provide orientation to provider staff on use of videoconferencing equipment, upon provider request. Members must complete a specific [PM Form 3.11.2 Informed Consent to Participate in Telemedicine](#) prior to the delivery of services. [PM Form 3.15.2 TMED](#) is a suggested format for documenting medication informed consent via telemedicine.

For more information regarding informed consent, please see [Section 3.11, General and Informed Consent to Treatment](#).

#### **3.15.7-D. Psychotropic Medication Monitoring**

Psychotropic medications must be monitored. While T/RBHAs may establish additional guidelines or timelines beyond ADHS/DBHS minimum requirements, at a minimum, these must include:

- Heart Rate and Blood Pressure  
On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated.
- Weight  
On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated.
- Abdominal girth  
For individuals at least 18 years old, on initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated.
- Body Mass Index (BMI)  
On initiation of any medication and at least every six months thereafter, or more frequently as clinically indicated.
- Abnormal Involuntary Movements (AIMS)  
On initiation of any antipsychotic medication and at least every six months thereafter, or more frequently as clinically indicated.
- Fasting glucose  
On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
- Lipids  
On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
- Complete Blood Count (CBC)

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On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.

- Liver function  
On initiation of any medication affecting this parameter and at least annually thereafter or more frequently as clinically indicated.
- Lithium level  
Within one month of initiation of lithium or significant change in dose and at least annually thereafter or more frequently as clinically indicated
- Thyroid function  
Within one month of initiation of lithium and at least annually thereafter or more frequently as clinically indicated.
- Renal function  
Within one month of initiation of lithium and at least annually thereafter or more frequently as clinically indicated.
- Valproic acid level  
Within one month of initiation of valproic acid or divalproex or significant change in dose and at least annually thereafter or more frequently as clinically indicated.
- Carbamazepine level  
Within one month of initiation of carbamazepine or significant change in dose and at least annually thereafter or more frequently as clinically indicated.

Type of Medication	Monitoring Action
Opiate dependence medications	It is not necessary that a behavioral health medical practitioner must always perform a psychiatric assessment on a member who is being referred to a Opiate Maintenance program prior to that referral, as the Opiate Maintenance Program medical practitioner is the treating physician who will make the determination as to the appropriateness of opiate maintenance medications. Methadone and other opiate dependence medications, such as buprenorphine, are provided as per federal and licensure standards. When opiate dependence medications are discontinued, they are tapered in a safe manner in order to minimize the risks of relapse and physiologic jeopardy.
Transition of medications when person loses medication benefit	Providers ensure that members who need to be disenrolled or who lose their NARBHA medication benefit while receiving psychotropic medications, including methadone, are monitored by an appropriate medical professional who

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	gradually and safely decreases the medication, or continues to prescribe the medication until an alternate provider has assumed responsibility for the member.
Out-of-area prescription refills of non-Schedule II medications	NARBHA maintains a comprehensive pharmacy network that includes many pharmacy chains. Members needing to fill NARBHA prescriptions while out-of-area should have their prescription transferred to a pharmacy chain that is located in the area where the prescription will be picked up. Members who run out or lose their medications while out-of area should contact their prescriber to determine the appropriateness of calling in a prescription to a contracted pharmacy near the member's location or to a local pharmacy with a chain pharmacy in that area. Members needing urgent after-hour or weekend refills of medications may receive compassionate dispensing of limited supplies at times from some pharmacists. Other options include presenting to local behavioral health agencies or urgent care centers. Use of emergency rooms for dispensing of routine psychotropic medications is discouraged. Valid member-incurred costs for covered medications can be reimbursed by NARBHA by sending a copy of the receipt and relevant documentation to the NARBHA Business Manager.
Out-of-area prescription refills of Schedule II medications	Schedule II medications, such as stimulants, are tightly controlled by federal and state regulations. These medications require a current printed and signed prescription. Prescribers may not call these medications in to pharmacies and running out of these medications is typically not a behavioral health emergency; therefore members should be advised to plan ahead to ensure adequate supplies of these medications. Members needing urgent after-hour or weekend refills of medications may receive compassionate dispensing of limited supplies from some pharmacists. Other options include presenting to local behavioral health agencies or urgent care centers. Use of emergency rooms for dispensing of routine psychotropic medications is discouraged.
Discharge medications from inpatient facilities	Dispense at least a 3 to 5 days supply of medications for the convenience of families and members at discharge. Give members prescriptions with enough medications and/or refills to last until the first scheduled prescriber appointment. As per <a href="#">Section 3.8 Outreach, Engagement, Re-Engagement and Closure</a> this should be within seven days (and in no case more than 30 days). If the prescriber is concerned about safety issues, then give smaller quantities per prescription but with more refills AND ensure that the member is prioritized to receive a post-discharge follow-up

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	<p>within clinically appropriate time frames. If the member is on STIMULANTS, give enough to last until the first prescriber appointment because stimulants can not be refilled or written in advance and because members will have to be seen by a prescriber to get a stimulant prescription. Having this medication run out before the prescriber appointment creates an administrative emergency for families and providers which is not necessary.</p> <p>FAX or send the outpatient facility the discharge prescriptions and medications dispensed so that it will know if members are running out of medications inappropriately early.</p>
<p>Medications during transitions between RBHAs, agencies or prescribers</p>	<p>It is the responsibility of the member's current prescriber to ensure that persons transitioning have adequate supplies of medications to last until the appointment with the next prescriber as per <a href="#">Section 3.17 Transition of Persons</a>. It is the responsibility of the provider assuming the person's care to ensure that the person is scheduled with an appointment within clinically appropriate time frames such that the person does not run out of medications, does not experience a decline in functioning and in no case longer than 30 days from identification of need as per <a href="#">Section 3.2 Timeliness of Service</a>. See <a href="#">Section 3.16 Medication Formulary</a> for procedures on handling current prescribers not on the NARBHA prescriber panel, non-formulary medications and ways to provide pharmacy benefit exceptions for not yet enrolled persons or non-TIXX/TXXI persons who don't yet have a pharmacy benefit.</p>
<p>Psychotropic medications for persons without a NARBHA pharmacy benefit who are experiencing a serious decline in functioning</p>	<p>Persons can be evaluated at any time during their care for SMI eligibility, not just at enrollment. Substance use disorders carry a high risk of morbidity and mortality and may obscure the ability to determine if a person has a qualifying SMI diagnosis. (See <a href="#">PM Attachment 3.10.2, Substance Use/Psychiatric Symptomatology Table</a>)</p> <p>Requiring that a person be substance-free prior to the initiation of services is not a best practice. Providers may determine that a person is SMI pending receipt of information and response to treatment. Periodic review within three to six months and SMI disenrollment of any person not meeting the criteria is allowed as per <a href="#">Section 3.10 SMI Eligibility Determination</a>. Other options include providing samples or pharmacy benefit exceptions for ineligible persons as per <a href="#">Section 3.16 Medication Formulary</a>. Additionally, Medicare-eligible persons must enroll in Part D Medication Plans.</p>

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#### 3.15.7-E. Polypharmacy

ADHS/DBHS recognizes two types of polypharmacy: intra-class polypharmacy and inter-class polypharmacy. (See [Polypharmacy Use: Assessment of Appropriateness and Importance of Documentation Practice Protocol](#)). Below are ADHS/DBHS expectations regarding prescribing multiple psychotropic medications to a person being treated for a behavioral health condition.

**Intra-class Polypharmacy:** Defined as more than two medications prescribed at the same time within the same class, other than for cross-tapering purposes. The person's medical record (See [Section 4.2, Behavioral Health Medical Record Standards](#)) must contain documentation specifically describing the rationale and justification for the combined use.

**Inter-class Polypharmacy:** Defined as more than three medications prescribed at the same time from different classes of medications for the overall treatment of behavioral health disorders. The medical record (See [Section 4.2, Behavioral Health Medical Record Standards](#)) must contain documentation specifically describing the rationale and justification for the combined use.

#### 3.15.7-F. Reporting requirements

ADHS/DBHS requires that T/RBHAs establish a system for monitoring the following:

- Adverse drug reactions
- Adverse drug event
- Medication errors

The above referenced events must be identified, reported, tracked, reviewed and analyzed by the T/RBHA. NARBHA Medical Department reviews and analyzes Medication Errors and Adverse Drug Reactions. If follow up by the provider was inadequate, corrective action to the provider is generated.

An incident report must be completed for any medication error, adverse drug event and/or adverse drug reaction that results in harm and/or emergency medical intervention. (See [Section 7.4, Reporting of Incidents, Accidents and Deaths](#) for more information).

#### 3.15.7-G. Complementary and alternative medicine (CAM)

Complementary and alternative medicine (CAM) is not AHCCCS reimbursable.

When a physician uses CAM, (See [The Arizona Medical Board's Guidelines For Physicians Who Incorporate Or Use Complementary Or Alternative Medicine In Their Practice](#)) informed consent must be obtained from the person and/or legal guardian for each CAM prescribed (See [PM 3.16, Medication Formulary](#)). When obtaining informed consent, behavioral health medical practitioners must communicate in a manner that the person and/or legal guardian can understand and comprehend. The comprehensive clinical record must include documentation of the essential elements for obtaining informed consent (See [Section 4.2, Behavioral Health Medical Record Standards](#)). Essential elements for obtaining informed consent for medication are contained within [PM Form 3.15.1, Informed Consent for Psychotropic Medication Treatment](#).

The use of [PM Form 3.15.1](#) is recommended as a tool to document informed consent for CAM. If [PM Form 3.15.1](#) is not used to document informed consent, the essential elements for obtaining informed consent must be documented in the person's individual comprehensive

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clinical record (See [Section 4.2, Behavioral Health Medical Record Standards](#)) in an alternative fashion.