Section 3.15  Psychotropic Medication: Prescribing and Monitoring

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. The Arizona Department of Health Services/Division of Behavioral Health Services (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;
- Help persons who are taking psychotropic medications restore and maintain optimal levels of functioning and achieve positive clinical outcomes;
- Ensure that psychotropic medications prescribed for persons are prescribed and monitored in a manner that provides for safe and effective use; and
- 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 shall 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).

3.15.2  Terms
Definitions for terms are located online at http://www.narbha.org/for-providers/provider-resources/provider-policy-manual/definitions/. or http://www.azdhs.gov/bhs/definitions/index.php. The following terms are referenced in this section:

- Adverse Drug Event (ADE)
- Adverse Drug Reaction (ADR)
- Behavioral Health Professional
- Complementary and Alternative Medicine (CAM)
- Cross-tapering
- Medication Error
3.15.3 Procedures
3.15.3-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 Recredentialing 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, 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, Medical Record Standards).

3.15.3-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, 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 professionals (BHMPs) 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:
- 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 psychotropic medications including any noted side effects and/or potential drug-drug interactions;
- Current medications prescribed by the PCP and medical specialists;
- Current over the counter (OTC) medications, including supplements:
For sexually active females of childbearing age, a review of reproductive status (pregnancy);

For post-partum females, a review of breastfeeding status; and

Minimum requirements as per 3.15.3-D.

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 reason for the use of the medication and the effectiveness of the medication;
- The appropriateness of the current dosage;
- All medication (including medications prescribed by the PCP and medical specialists, OTC medications, and supplements) being taken and the appropriateness of the combination of the medications;
- Any side effects such as weight gain and/or abnormal/involuntary movements if treated with an anti-psychotic medication; and
- Minimum requirements as per 3.15.3-D.

3.15.3-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 BHMP must communicate in a manner that the person and/or legal guardian can understand and comprehend. 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 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 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).

For more information regarding informed consent, please see Section 3.11, General and Informed Consent to Treatment.

Transitioning Youth and Psychotropic Medications

Youth under the age of 18 are educated on options, allowed to provide input, and encouraged to assent to medication(s) being prescribed. Information is discussed with the youth in a clear and age-appropriate manner consistent with the developmental needs of the youth. Discussion of
the youth’s ability to give consent for medications at the age of 18 years old is begun no later than age 17 ½ years old, especially for youth who are not in the custody of their parents. There should be special attention to the effect of medications on reproductive status and pregnancy, as well as long term effects on weight, abnormal involuntary movements and other health parameters. Evidence of the youth’s consent to continue medications after his/her 18th birthday may be documented through use of PM Form 3.15.1, a recommended tool to review and document informed consent for psychotropic medications.

3.15.3-D. Psychotropic Medication Monitoring
Psychotropic medications are known to affect health parameters. Depending on the specific psychotropic medication(s) prescribed, these parameters must be monitored according to current national guidelines, taking into account individualized factors. 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 and/or Hgb A1c**
  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)**
  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 every six months 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.

- **Review of all Medications**
  Including medications prescribed by the PCP and medical specialists, OTC medications, and supplements at least annually or more frequently as clinically necessary.

- **Children** are more vulnerable than adults with regard to developing a number of antipsychotic induced side effects. These included higher rates of sedation, extrapyramidal side effects (except for akathisia), withdrawal dyskinesia, prolactin elevation, weight gain and at least some metabolic abnormalities. *(Journal of Clinical Psychiatry 72:5 May 2011)*

- **Persons with developmental disabilities on antipsychotic medications** need to be identified for risk of, or development of, Metabolic Syndrome prior to, and while, being prescribed a “new generation/second generation” antipsychotic medication regardless of the reason that medication is being prescribed.
  - Documentation must include justification of the choice of and continued use of the specific medications prescribed. See [AHCCCS AMPM 1020-7](#). Also see [PM Attachment 3.15.2 – ADHS/DBHS ISA effective April 2014](#).
  - Basic health parameter screening requirements are the same as for all persons on psychotropic medications (heart rate, weight, blood pressure, BMI, waist circumference, fasting glucose and/or Hgb A1c, and lipids).
  - At-risk members showing emerging abnormalities, Metabolic Syndrome, or trends towards Metabolic Syndrome, need to be followed more closely, including educating the member, guardian and caregivers on self-management strategies, such as diet,
exercise, sleep hygiene, stress management and consideration of alternatives to antipsychotic medications for symptom management.

- Results of lab values, especially abnormal labs, should be coordinated with the member’s primary care practitioner as per Provider Manual 4.3 Coordination of Care with AHCCCS Health Plans and PCPs.
- For risk factors and lab values indicating additional interventions, see attached Metabolic Syndrome Screening and Monitoring Tool (PM Attachment 3.15.1) developed by the State of Missouri Department of Mental Health. Use of this tool is not required, but identifying risk, Metabolic Syndrome and interventions are required.
- Links to Pediatric Growth Charts and Child and Adult BMI calculators are available on AHCCCS Medical Policy Manual Appendix 1-
  - The boys and girls BMI charts were obtained from the Centers for Disease Control at http://www.cdc.gov/growthcharts/.
  - The Adult BMI chart was obtained from the national Institutes of Health (National Heart, Lung and Blood Institute) at http://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

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<th>Type of Medication</th>
<th>Monitoring Action</th>
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<td>Controlled Substances</td>
<td>Prescribers should check the Arizona Pharmacy Board’s Controlled Substance Prescription Monitoring Program (CSPMP) when initiating a controlled substance (i.e. amphetamines, opiates, benzodiazepines, etc.) that will be used on a regular basis, and then at least annually or whenever there appears to be a significant change or concern in the person's presentation. This includes when it is known that the person is receiving opioid pain medications or pain management. Medical decision-making regarding the results should be documented in the medical record. Health Plans may consider members for single pharmacy/provider locks. Send requests for consideration to <a href="mailto:PCP@narbha.org">PCP@narbha.org</a>.</td>
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<td>Opiate dependence medications</td>
<td>It is not necessary that a behavioral health medical practitioner must always perform a psychiatric assessment on a member who is being referred to an 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.</td>
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<td>Transition of medications when person loses medication benefit</td>
<td>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</td>
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3.15 – Psychotropic Medication: Prescribing and Monitoring
Last Revised: 06/23/2014
Effective Date: 08/01/2014
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<tr>
<th>Type of Medication</th>
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<td>gradually and safely decreases the medication, or continues to prescribe the medication until an alternate provider has assumed responsibility for the member.</td>
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<td>Out-of-area prescription refills of non-Schedule II medications</td>
<td>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.</td>
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<td>Out-of-area prescription refills of Schedule II medications</td>
<td>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 into 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.</td>
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<td>Discharge medications from inpatient facilities</td>
<td>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 Section 3.8 Outreach, Engagement, Re-Engagement and Closure 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 within clinically appropriate time frames. If the member is on</td>
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<td>STIMULANTS, give enough to last until the first prescriber appointment because stimulants cannot 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. 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.</td>
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| Medications during transitions between RBHAs, agencies or prescribers | 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 **Section 3.17 Transition of Persons**. 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 **Section 3.2 Timeliness of Service**. See **Section 3.16 Medication Formulary** 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. |

| Psychotropic medications for persons without a NARBHA pharmacy benefit who are experiencing a serious decline in functioning | 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 **PM Attachment 3.10.2, Substance Use/Psychiatric Symptomatology Table**). 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 **Section 3.10 SMI Eligibility Determination**. Other options include providing samples or pharmacy benefit exceptions for ineligible persons as per **Section 3.16 Medication Formulary**. Additionally, Medicare-eligible persons must enroll in Part D Medication Plans. |
3.15.3-E. Polypharmacy
Commonly used psychotropic medication combinations include the following: medication combinations used to treat multiple disorders in the same patient, medication combinations that offer unique treatment advantages for a single disorder, and medication combinations to address side effects of an effective agent (Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY, 48:9, SEPTEMBER 2009).

ADHS/DBHS recognizes two types of polypharmacy: intra-class polypharmacy and inter-class polypharmacy. 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, 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, Medical Record Standards) must contain documentation specifically describing the rationale and justification for the combined use.

- Polypharmacy in Children aged Birth to Five: Defined as use of more than one psychotropic medication at a time (see ADHS/DBHS Practice Guidelines for Children: Birth to Five Years of Age)

3.15.3-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.

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).

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

When a BHP uses Complementary and Alternative Medicine (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 or guardian, when applicable, for each CAM prescribed (See PM 3.16, ADHS/DBHS Drug List). 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, 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 clinical record (see Section 4.2, Medical Record Standards) in an alternative fashion.

3.15.4 References
The following citations 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, ADHS/DBHS Drug List
Section 3.20, Credentialing and Recredentialing
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
ADHS/DBHS Practice Guidelines, Psychiatric Best Practice for Children: Birth to Five Years of Age
ADHS/DBHS Drug List and Prior Authorization Guidance Documents webpage
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
ADHS/DBHS Practice Guidelines, Psychiatric Best Practice for Children: Birth to Five Years of Age
American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameter on the Use of Psychotropic Medication in Children and Adolescents
Missouri Department of Mental Health forms: http://dmh.mo.gov/mentalillness/provider/forms.htm
Missouri Department of Mental Health Metabolic Syndrome Screening and Monitoring Tool: http://dmh.mo.gov/docs/mentalillness/MetabolicSyndromeScreeningandMonitoringTool.pdf
PM Attachment 3.15.1 Missouri Department of Mental Health Metabolic Syndrome Screening and Monitoring Tool (Permission for use approved by State of Missouri-Department of Mental Health March 2014)

3.15.5 PM Forms
PM Form 3.15.1, Informed Consent for Psychotropic Medication Treatment

3.15.6 PM Attachments
PM Attachment 3.15.1 Missouri Department of Mental Health Metabolic Syndrome Screening and Monitoring Tool

Signature on file 08/01/14
Mary Jo Gregory Date
President and Chief Executive Officer

Signature on file 08/01/14
Teresa Bertsch, MD Date
Chief Medical Officer

Reference ADHS/DBHS Policy 108