



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

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3.15.1 Introduction

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) developed guidelines and minimum requirements designed to guide the T/RBHAs in developing appropriate psychotropic medication use policies and procedures to:

- Promote the safety of persons taking psychotropic medications;
- Reduce or prevent the occurrence of adverse side effects;
- Promote positive clinical outcomes for behavioral health recipients who are taking psychotropic medications;
- Monitor the use of psychotropic medications to foster safe and effective use; and
- To clarify that medication will not be used for the convenience of the staff, in a punitive manner, 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 licensed psychiatrist psychiatric nurse practitioner, physician assistant, or other physician trained or experienced in the use of psychotropic medication. The prescribing clinician must have seen the client and is familiar with the client's medical history or, in an emergency, the prescribing clinician 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 prescribing of psychotropic medications. To the extent possible, candidates for psychotropic medication use 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 or other medications including any reported side effects and/or potential drug-drug interactions and all medications (including medications prescribed by the PCP and medical specialists, OTC medications, and supplements) currently being taken for the appropriateness of the combination of the medications;



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- For sexually active females of childbearing age, a review of reproductive status (pregnancy);
- For post-partum females, a review of breastfeeding status; and

A review of the recipient's profile in the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) database when initiating a controlled substance (i.e. amphetamines, opiates, benzodiazepines, etc.) that will be used on a regular basis or for short term addition of agents when the client is known to be receiving opioid pain medications or another controlled substance from a secondary prescriber.

Reassessments require that the prescribing clinician of psychotropic medication to note in the client's record the following (see [Section 4.2, Behavioral Health Medical Record Standards](#)):

- The reason for and the effectiveness of the medication
- The clinical 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 of this Policy
- Rationale for the use of more than three different psychotropic medications in adults, and
- Rationale for the use of more than one psychotropic medication in the child and adolescent population..

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 easily understand. 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 a registered nurse.

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](#).

Youth and Psychotropic Medications

- Youth under the age of 18 are to be 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.
- The information to be shared should be consistent with the information shared in obtaining informed consent from adults.
- 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 the 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

Per national guidelines and to address, the monitoring of psychotropic medications and metabolic parameters, the T/RBHAs must establish policies and procedures for monitoring lithium, valproic acid, carbamazepine, renal function, liver function, thyroid function, glucose metabolism, screening for metabolic syndrome and movement disorders.

- Medications prescribed for Youth must be monitored for efficacy, side effects and adverse events at each visit with a registered nurse, physician assistant, psychiatric nurse practitioner, or physician.
- **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,



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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-
<http://www.azahcccs.gov/shared/Downolads/MedicalPolicyManual/AppendixI.pdf>
 - 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

Type of Medication	Monitoring Action
Controlled Substances	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 PCP@narbha.org .
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 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.
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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Type of Medication	Monitoring Action
	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 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



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Type of Medication	Monitoring Action
	<p>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.</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 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.</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 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.</p>



3.15.3-E. 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-F. 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 easily understand. 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](#)

[R9-21-206.01](#)

[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](#)

[AHCCCS Medical Policy Manual Appendix 1:](#)

<http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Appendix1.pdf>

[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](#)



Northern Arizona Regional Behavioral Health Authority
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Signature on file 07/31/15

Mary Jo Gregory Date
President and Chief Executive Officer

Signature on file 07/31/15

Teresa Bertsch, MD Date
Chief Medical Officer

[Reference ADHS/DBHS Policy 108](#)