Iowa Department of Human Services

Request for Prior Authorization
SHORT ACTING OPIOIDS

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for all non-preferred short acting opioids. Payment will be considered under the following conditions: 1) Patient has pain severe enough to require opioid treatment; and 2) Patient has tried and failed at least two nonpharmacologic therapies; and 3) Patient has tried and failed at least two nonopioid pharmacologic therapies; and 4) Patient has documentation of previous trials and therapy failures with three (3) chemically distinct preferred short acting opioids (based on opioid ingredient only) at therapeutic doses; and 5) The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website at https://pmp.iowa.gov/IAPMPWebCenter/ and has determined that use of a short-acting opioid is appropriate for this member based on review of PMP and the patient's risk for opioid addiction, abuse and misuse prior to requesting prior authorization; and 6) Patient has been informed of the common adverse effects and serious adverse effects of opioids. If criteria for coverage are met, an initial authorization will be given for 3 months. Additional approvals will be considered if the following criteria are met: 1) Patient has experienced improvement in pain control and level of functioning; and 2) Prescriber has reviewed the patient's use of controlled substances on the Iowa PMP website and has determined continued use of a short-acting opioid is appropriate for this member. The required trials may be overridden when documented evidence is provided that use of these agents and/or non-pharmacologic therapies would be medically contraindicated.

Preferred (*Please refer to the PDL for a complete list of preferred alternatives)

Acetaminophen/Codeine
Hydrocodone/APAP
Hydromorphone Tab
Meperidine Tab
Morphine Sulfate Tab
Oxycodone Cap/Tab
Oxycodone /APAP (5/325)
Oxycodone/ASA
Tramadol

Non-Preferred

- ☐ Butalbital/APAP/Caff/Codeine
- ☐ Butalbital/ASA/Caff/Codeine
- ☐ Combunox
- ☐ Hydrocodone/APAP (5/300, 7.5/300, 10/300)
- ☐ Hydrocodone/Ibuprofen
- ☐ Hydromorphone Inj
- ☐ Meperidine Syp/Inj
- ☐ Nucynta
- ☐ Opana
- ☐ Oxycodone/APAP (7.5/325, 10/325)
- ☐ Primlev
- ☐ Roxicodone
- ☐ Xodol
- ☐ Other **(**specify)_____

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**

Diagnosis:_____

Document non-pharmacologic therapies (such as physical therapy, weight loss, alternative therapies such as manipulation, massage, and acupuncture, or psychological therapies such as cognitive behavior therapy [CBT], etc,)

Non-Pharmacological Treatment Trial #1: _____
Trial Dates: _____ Failure reason: _____

Non-Pharmacological Treatment Trial #2: _____
Trial Dates: _____ Failure reason: _____

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Document 2 nonopioid pharmacologic therapies (acetaminophen or NSAIDs)

Nonopioid Pharmacologic Trial #1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Nonopioid Pharmacologic Trial #2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Document trials with three preferred chemically distinct short acting opioids

Preferred Trial 1: Drug Name_____ Strength_____ Dosage Instructions_____

Trial start date:_____ Trial end date:_____

Failure reason:_____

Preferred Trial 2: Drug Name_____ Strength_____ Dosage Instructions_____

Trial start date:_____ Trial end date:_____

Failure reason:_____

Preferred Trial 3: Drug Name_____ Strength_____ Dosage Instructions_____

Trial start date:_____ Trial end date:_____

Failure reason:_____

Prescriber review of patient's controlled substances use on the Iowa PMP website: ☐ No ☐ Yes Date Reviewed:___

Is short-acting opioid use appropriate for patient based on PMP review and patient's risk for opioid addiction, abuse and misuse? ☐ No ☐ Yes

Has patient been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids?

☐ No ☐ Yes

Renewals

Has patient experienced improvement in pain control and level of functioning?

☐ No ☐ Yes (describe): _____

Updated prescriber review of patient's controlled substances use on the Iowa PMP website (since initial request):
☐ No ☐ Yes Date Reviewed:_____

Continued use of a short-acting opioid is appropriate for this member?

☐ No ☐ Yes (describe): _____

Other medical conditions to consider:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*