Iowa Department of Human Services

Request for Prior Authorization
High Dose Opioids

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

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 use of high-dose opioids ≥ 200 morphine milligram equivalents (MME) per day. (See CDC Guideline for Prescribing Opioids for Chronic Pain at https://www.cdc.gov/drugoverdose/prescribing/guideline.html.) Patients undergoing active cancer treatment or end-of-life care will not be subject to the criteria below. Payment will be considered when the following is met:

1. Requests for non-preferred opioids meet criteria for coverage (see criteria for Long-Acting Opioids and/or Short-Acting Opioids); and
2. Patient has a diagnosis of severe, chronic pain with a supporting ICD-10 code. Requests for a diagnosis of fibromyalgia or migraine will not be considered; and
3. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy (CBT); and
4. Patient has tried and failed at least two nonopioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants); and
5. There is documentation demonstrating an appropriate upward titration or an appropriate conversion from other opioid medications; and
6. Pain was inadequately controlled at the maximum allowed dose without prior authorization for the requested opioid(s); and
7. Pain was inadequately controlled by two other chemically distinct preferred long-acting opioids at the maximum allowed dose without prior authorization; and
8. Chart notes from a recent office visit for pain management is included documenting the following: a) Treatment plan, including all therapies to be used concurrently (pharmacologic and nonpharmacologic); and b) Treatment goals; and
9. Patient has been informed of the risks of high-dose opioid therapy; and
10. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determined that use of high-dose opioid therapy is appropriate for this patient; and
11. The patient's risk for opioid addiction, abuse and misuse has been reviewed and prescriber has determined the patient is a candidate for high-dose opioid therapy; and
12. A signed chronic opioid therapy management plan between the prescriber and patient dated within 12 months of this request is included; and
13. The requested dosing interval is no more frequent than the maximum FDA-approved dosing interval; and
14. Patient has been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose; and
15. Patient has been educated on opioid overdose prevention; and
16. Patient's household members have been educated on the signs of opioid overdose and how to administer naloxone; and
17. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with initial and subsequent requests; and
18. A documented dose reduction is attempted at least annually.

If criteria for coverage are met, initial requests will be given for three months. Requests for continuation of high-dose opioid therapy will be considered every six months with the following:

1. High-dose opioid therapy continues to meet treatment goals, including sustained improvement in pain and function; and
2. Patient has not experienced an overdose or other serious adverse event; and

Request for Prior Authorization
High Dose Opioids
(PLEASE PRINT – ACCURACY IS IMPORTANT)

3. Patient is not exhibiting warning signs of opioid use disorder; and
4. The benefits of opioids continue to outweigh the risks; and
5. A documented dose reduction has been attempted at least annually, and the prescriber has determined the dose cannot be reduced at this time; and
6. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determined that continued use of high-dose opioid therapy is appropriate for this patient; and
7. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with subsequent requests; and
8. Patient has been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose; and
9. Patient has been reeducated on opioid overdose prevention; and
10. Patient's household members have been reeducated on the signs of opioid overdose and how to administer naloxone.

Drug name:_____ Strength:_____

Dosage instructions:_____ Quantity:_____ Days supply:_____

Drug name:_____ Strength:_____

Dosage instructions:_____ Quantity:_____ Days supply:_____

Diagnosis:_____ **ICD-10 code:**_____
* Proceed to Prescriber Signature for active cancer treatment or end of life care diagnoses.

Initial Requests:

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:_____

Document two nonopioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants, and anticonvulsants)

Nonopioid pharmacologic trial #1: Name/dose:_____

Trial dates:_____ Failure reason:_____

Nonopioid pharmacologic trial #2: Name/dose:_____

Trial dates:_____ Failure reason:_____

Document upward titration or conversion from other opioid medications:_____

_____

_____

Was pain inadequately controlled at the maximum dose allowed without prior authorization for the requested opioid(s)?
☐ No ☐ Yes Document dose and trial dates:_____

Was pain inadequately controlled by two other chemically distinct preferred long-acting opioids at the maximum dose allowed without prior authorization? ☐ No ☐ Yes Document below.

Preferred long-acting narcotic trial #1: Name/dose:_____

Trial dates:_____ Failure reason:_____

Preferred long-acting narcotic trial #2: Name/dose:_____

Trial dates:_____ Failure reason:_____

Request for Prior Authorization
High Dose Opioids

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Attach notes from a recent office visit for pain management documenting both of the following:

☐ Treatment plan, including all therapies to be used concurrently (pharmacologic and nonpharmacologic)
☐ Treatment goals

Has patient been informed of the risks of high-dose opioid therapy? ☐ No ☐ Yes

Prescriber review of patient's controlled substance use on the Iowa PMP website: ☐ No ☐ Yes
Date reviewed:_____

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

Attach a signed chronic opioid therapy management plan between the prescriber and patient dated **within 12 months of this request**.

Has patient been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose? ☐ No ☐ Yes Date RX written:_____

Has patient been educated on opioid overdose prevention? ☐ No ☐ Yes Date:_____

Has patient's household members been educated on the signs of opioid overdose and how to administer naloxone?
☐ No ☐ Yes Date:_____

Is patient using opioids and benzodiazepines concurrently? ☐ No ☐ Yes (provide taper plan to discontinue the benzodiazepine)

Date of patient's most recent documented dose reduction:_____

Renewals:

Does high-dose opioid therapy continue to meet treatment goals, including sustained improvement in pain and function?
☐ No ☐ Yes (describe):_____

Has patient experienced an overdose or other serious adverse event? ☐ No ☐ Yes

Is patient exhibiting warning signs of opioid use disorder? ☐ No ☐ Yes

Do the benefits of opioids continue to outweigh the risks? ☐ No ☐ Yes

Date of patient's most recent documented dose reduction:_____

Updated prescriber review of patient's controlled substances use on the Iowa PMP website: ☐ No ☐ Yes
Date reviewed:_____

Is patient using opioids and benzodiazepines concurrently? ☐ No ☐ Yes (provide taper plan to discontinue the benzodiazepine)

Has patient been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose? ☐ No ☐ Yes Date RX written:_____

Has patient been reeducated on opioid overdose prevention? ☐ No ☐ Yes Date:_____

Has patient's household members been reeducated on the signs of opioid overdose and how to administer naloxone?
☐ No ☐ Yes Date:_____

Attach a signed chronic opioid therapy management plan between the prescriber and patient dated **within 12 months of this request.**

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.*