



Request for Prior Authorization
SHORT ACTING OPIOIDS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, 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 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 Oxycodone /APAP (5/325)
Hydrocodone/APAP Oxycodone/ASA
Hydromorphone Tab Oxycodone/ASA
Meperidine Tab Tramadol
Morphine Sulfate Tab
Oxycodone Cap/Tab

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.