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 (PA)is required for all non-preferred short acting opioids. PA is also required for members when the total daily opioid dose (combined across all opioids) exceeds the set morphine milligram equivalent (MME) threshold (include High Dose Opioids PA form with request). 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; and 7) For patients taking concurrent benzodiazepines, the prescriber must document the following: a. The risks of using opioids and benzodiazepines concurrently has been discussed with the patient; and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. 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. 3) For patients taking concurrent benzodiazepines, the prescriber must document the following: a. the risks of using opioids and benzodiazepines concurrently has been discussed with the patient, and b. Documentation as to why concurrent use is medically necessary is provided; and c. A plan to taper the benzodiazepine is provided, if appropriate. 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
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
- ☐ Meperidine
- ☐ Nucynta
- ☐ Opana
- ☐ Oxycodone/APAP (7.5/325, 10/325)
- ☐ Primlev
- ☐ Roxicodone
- ☐ Xodol
- ☐ Other (specify)_____

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis:_____

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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 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

Patients taking concurrent benzodiazepines:

Have the risks of using opioids and benzodiazepines concurrently been discussed with the patient? ☐ No ☐ Yes

Medical necessity for concurrent use: _____
_____

Provide plan to taper the benzodiazepine or medical rationale why not appropriate: _____
_____

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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): _____

Patients taking concurrent benzodiazepines:

Have the risks of using opioids and benzodiazepines concurrently been discussed with the patient? ☐ No ☐ Yes

Medical necessity for concurrent use: _____

_____

Provide plan to taper the benzodiazepine or medical rationale why not appropriate: _____

_____

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.*