Molina Healthcare of Utah
Opioid Prior Authorization Request Form
Medicaid
Phone Number: (855) 322-4081

FAX FORM AND RELEVENT DOCUMENTATION INCLUDING: LABORATORY RESULTS (AS APPLICABLE) AND CHART NOTES TO (866) 497-7448

MEMBER INFORMATION				
MEMBER NAME (LAST, FIRST, MIDDLE INITIAL):	Member Molina ID #:	DATE OF BIRTH: ___ /___ /___	WEIGHT: _____kg/lbs	
CURRENT ADDRESS:	CITY:		STATE:	ZIP:

PRESCRIBER INFORMATION		
PRESCRIBER NAME (LAST, FIRST):	PRESCRIBER SPECIALTY:	NPI NUMBER:
OFFICE CONTACT NAME:	PHONE NUMBER: ( )	FAX NUMBER: ( )

MEDICATION INFORMATION			
_____ URGENT _____ REAUTHORIZATION			
DRUG NAME, STRENGTH AND DIRECTIONS:			
PHARMACY NAME	PHONE #:	FAX #:	PHARMACY NPI
DIAGNOSIS/MEDICAL JUSTIFICATION:			
PREVIOUS MEDICATIONS TRIED AND DATES OF USE:			
COMMENTS:			

Short-Acting Opioids: *Prior Authorization may not be required if member has filled initial script of the same medication for a 7 day supply or 3 day for dental providers.*

1) Is the formulary quantity limit or limit of 90 Morphine Milligram Equivalent (MME) per day exceeded? ☐YES or ☐NO Clinical rationale if yes: _____
_____
_____ Chart note page#: _____
2) Is the member receiving larger days supply than initial fill limits? ☐YES or ☐NO
Clinical rationale if yes: _____
_____ Chart note page# _____
3) Documentation member has treatment plan/goals or other measures that provide baseline status to evaluate stabilization/improvement for member: _____
_____
_____ Chart note page# _____

Long-Acting Opioids: *Prior Authorization may not be required if member has filled short acting opioid within 30 days of initiating therapy on a long acting opioid*

1) Is the member younger than 18 years old? ☐YES or ☐NO Clinical rationale if yes: _____
_____
_____ Chart note Page# _____
2) Is the member pregnant? ☐YES or ☐NO Clinical rationale if yes: _____
_____
_____ Chart note Page# _____
3) Has the member has received a short acting opioid in the past 30 days? ☐YES or ☐NO
Clinical rationale if no: _____
Chart note Page#: _____
4) Is the request for greater than the CDC recommended limit of 90 morphine milligram equivalent (MME) per day? ☐YES or ☐NO Clinical rationale if yes: _____
_____
_____ Chart note Page# _____
5) Non-opioid pain medication history. Member is using or has tried and failed at least two of the following: **NSAIDs, non- opioid analgesics, antidepressants, or anticonvulsants**.
1- Medication name, strength and details of failure (including duration): _____
_____
_____ Chart note Page#: _____
2- Medication name, strength and details of failure (including duration):_____
_____
_____ Chart note Page# _____
6) Non-pharmacologic therapy. Member is using or has tried and failed at least two of the following: **Physical or occupational therapy, exercise, cognitive behavioral therapy, weight loss, or neurostimulation.**
Therapies used and details of failure (including duration): _____
_____
_____
_____
_____ Chart note Page# _____

Non-Preferred Opioids:

1) Does the member have a documented trial and failure of at least one preferred (formulary) agent in the drug class? ☐YES or ☐NO
   Medication name and strength: _____
   _____ Chart note page#: _____
   Details of failure (including duration): _____
2) Please provide clinical rationale for non-preferred (non-formulary) request: _____
   _____
   _____ Chart note page# _____

Opioid and Benzodiazepine Combination: FDA Black Box Warning

1) Has the member received benzodiazepine and opioid within last 45 days? ☐YES or ☐NO:
   Clinical rationale for this combination if yes: _____
   _____
   Chart note page#: _____
2) Most recent opioid prescription information:
   Medication name and strength: _____
   Quantity/Days Supply: _____ Date Prescribed: _____
3) Most recent benzodiazepine prescription information:
   Medication name and strength: _____
   Quantity/Days Supply: _____ Date Prescribed: _____

☐ **Provider attestation:** Provider has addressed the black box warning for the risks of combining benzodiazepines and opioids together including profound sedation, respiratory depression, coma, and death. Patients will be closely followed for signs and symptoms of respiratory depression and sedation. Dosages and durations will be limited to the minimum required.

Fentanyl products: *Certain forms and strengths of Fentanyl may be approved for active treatment of cancer related pain, palliative care, or end of life care only*

1) Is the request for a fentanyl product? ☐YES or ☐NO Patient diagnosis if yes: _____
   _____ Chart note page#: _____
2) Is the member is opioid tolerant (taking at least 60 mg of morphine milligram equivalents per day for at least one week)? ☐YES or ☐NO Medication name, strength, and duration of use:
   _____
   _____ Chart note Page# _____
3) Has the member has tried and failed at least one formulary long-acting opioid? ☐YES or ☐NO
   Medication name, strength, and duration of use: _____
   _____
   _____ Chart note Page#: _____

Methadone: *this form is for the treatment of chronic pain only*

Criteria for Approval (Minimum age requirement of 18 years old):

☐ The prescriber has assessed the following prescribing information boxed warnings:

- **ADDICTION, ABUSE AND MISUSE:** methadone exposes users to risks of addiction, abuse, and misuse, which can lead to overdose and death. Assess each patient's risk before prescribing and monitor regularly for development of these behaviors or conditions.
- **LIFE-THREATENING RESPIRATORY DEPRESSION:** Serious, life-threatening, or fatal respiratory depression may occur. Monitor closely, especially upon initiation or following a dose increase.
- **ACCIDENTAL INGESTION**: Accidental ingestion of methadone, especially in children, can result in fatal overdose of methadone
- **LIFE-THREATENING QT PROLONGATION:** QT interval prolongation and serious arrhythmia (torsades de pointes) have occurred during treatment with methadone.
- **NEONATAL OPIOID WITHDRAWAL SYNDROME:** Prolonged use of methadone during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available.

☐ Documentation the member is opioid tolerant
Medication used: _____
Duration of use: _____
Chart Note Page #: _____

☐ Member has not received a benzodiazepine within the past 45 days

☐ Member has not received any buprenorphine-naloxone combination, buprenorphine, naloxone or naltrexone medication within the past 18 months.

Prescriber Criteria:

☐ Include a treatment agreement, including discontinuation criteria, signed by the provider and the member.

☐ Prescriber must hold and provide copy of a current American Board of Medical Specialties (ABMS) Pain Medicine Subspecialty Certificate or equivalent training. **OR**

☐ Must work in continued consultation with a prescriber that holds a current ABMS Pain Medicine Subspecialty Certificate.

Note:

- The maximum dose per day that can be approved for non-cancer pain is 20mg and existing opioid limits still apply.

Opioid Tapering Plan: Provider must discuss possible reduction in dose, tapering and discontinuation of opioids with member.

1) Does the request exceed the formulary quantity limit or MME limit of 90 MME/day?
☐YES or NO☐Clinical rationale if yes: _____
_____

2) Details of taper plan or rationale for the lack thereof: _____
_____
_____ Chart note Page#: _____

Provider Attests to all of the following:

- □ Provider has a signed opioid treatment agreement with the member.
- □ Provider has checked the Utah's Controlled Substance Database with each prescription.
- □ Provider has discussed with the member benefits and potential harm, including combining opioids with other CNS depressants.
- □ Provider has counseled members with high-risk conditions (sleep apnea, pregnancy, mental health conditions, substance abuse disorders, or children) about the heightened risk of using opioids.
- □ Member has been evaluated and will be monitored regularly for the development of addiction, abuse/misuse, or diversion of the requested drug.
- □ Member has received naloxone education.

The submitting provider certifies that the information provided on this form is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Prescriber's Signature _____ Date_____

Documentation Requirements:

Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

Confidentiality Notice:

This document contains confidential health information that is protected by law. The information herein is confidential and intended only for use by the designated recipient who/which must maintain its confidentiality and security. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distributions, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately by telephone at above phone number and arrange for the return or destruction of these documents.