

Iowa Department of Human Services



Request for Prior Authorization High Dose Opioids

FAX Completed Form To 1 (877) 733-3195 Provider Help Desk 1 (844) 236-1464

(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 informa	tion 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 \geq 90 morphine milligram equivalents (MME) per day. (See CDC Guideline for Prescribing Opioids for Chronic Pain at <u>https://www.cdc.gov/drugoverdose/prescribing/guideline.html</u>.) 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
- 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
- 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
 Patient has been informed of the risks of high-dose opioid therapy; and
- 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

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- 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 c	ancer treatment or end of life care diagnos		

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 the anticonvulsants)	rapies (acetaminophen, NSAIDs, or selected antidepressants, and
Nonopioid pharmacologic trial #1: Name/dose:	
	Failure reason:
Nonopioid pharmacologic trial #2: Name/dose:_	
Trial dates:	Failure reason:
Document upward titration or conversion fro	m other opioid medications:
	Im dose allowed without prior authorization for the requested opioid(s)?
Was pain inadequately controlled by two other c allowed without prior authorization?	hemically distinct preferred long-acting opioids at the maximum dose Yes Document below.
Preferred long-acting narcotic trial #1: Name/dos	se:
Trial dates:	Failure reason:
Preferred long-acting narcotic trial #2: Name/dos	se:
Trial dates:	Failure reason:

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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?
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?
Has patient been educated on opioid overdose prevention?
Has patient's household members been educated on the signs of opioid overdose and how to administer naloxone?
Is patient using opioids and benzodiazepines concurrently?
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):
Does high-dose opioid therapy continue to meet treatment goals, including sustained improvement in pain and function?
Does high-dose opioid therapy continue to meet treatment goals, including sustained improvement in pain and function?
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
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
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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.