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

Member and Medication Information (required)	
Member ID #:	Member name:
DOB:	Weight:
Medication name/strength:	Dose:
Directions for use:	
Diagnosis/Medical Justification:	
(If applicable, please select the following diagnoses and provide documentation): ☐ Cancer treatment ☐ Hospice or palliative care ☐ Residents of long-term care facility	
Previous Medications Tried and Dates of Use:	
Comments:	

Provider Information (required)		
Name:	NPI:	Specialty:
Contact Person:	Office Phone:	Office Fax:
FAX FORM AND RELEVANT DOCUMENTATION INCLUDING: LABORATORY RESULTS (AS APPLICABLE) AND CHART NOTES TO (866) 497-7448		

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.*

☐ Clinical rationale for member not receiving initial 7-day fill:

_____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.*

☐ Clinical rationale for member not receiving short acting opioid in past 30 days:

_____Chart Note Page #: _____

☐ 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.

Medication:_____Chart Note Page #: _____

Details of failure (including duration): _____

Medication:_____Chart Note Page #: _____

Details of failure (including duration): _____

Dose, Age, Pregnancy, MME and/or Quantity Limits Exception Criteria for Approval: *Taper plan must be provided for all limit exception requests.*

☐ Clinical rationale for member under 18 years of age receiving long-acting opioid or more than 7-day supply short-acting opioid:

_____Chart Note Page #: _____

☐ Clinical rationale for pregnant member receiving long-acting opioid or more than 7-day supply short-acting opioid:

_____Chart Note Page #: _____

☐ Clinical rationale for exceeding formulary quantity limits or Utah Medicaid Morphine Milligram Equivalent (MME) limit of 90 MME/day:

_____Chart Note Page #: _____

☐ **Details of taper plan** or rationale for the lack thereof of:

_____Chart Note Page #: _____

Opioid and Benzodiazepine Combination: FDA Black Box Warning

☐ Clinical rationale and diagnosis for member receiving concomitant benzodiazepine and opioid within last 45 days:

_____Chart Note Page #: _____

☐ Most recent opioid prescription information:

Medication Name and Strength:_____Quantity/Day Supply:_____Date Prescribed:_____

☐ Most recent benzodiazepine prescription information:

Medication Name and Strength:_____Quantity/Day Supply:_____Date Prescribed:_____

Non-Preferred Opioids: *(Criteria above must also be met)*

☐ Trial and failure of preferred (formulary) opioid in same class with appropriate dose and duration:

Medication(s):_____Chart Note Page #: _____

Dates of therapy:_____ Details of Failure: _____

☐ Appropriate clinical rationale for prescribing the non-preferred product: *(i.e. adverse reaction, allergy, or contraindication)*

_____

Methadone Criteria for Approval: *(Minimum age requirement: 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.

☐ Patient is opioid tolerant. Medication(s) used: _____

Dates of therapy:_____Chart Note Page #:_____

☐ Patient has not received a benzodiazepine within the past 45 days.

☐ Patient has not received buprenorphine, naloxone, naltrexone or combination of, 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.

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Note:

- This PA form is for the treatment of chronic pain only. Methadone used for the treatment of opioid use disorder should be administered through a treatment facility and billed through the medical benefit as part of comprehensive MAT.
- This PA does NOT override existing opioid limits.
- The max dose per day that can be approved for non-cancer pain is 20mg.

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 received naloxone education.

PROVIDER CERTIFICATION

I certify that the information provided on this form is true and accurate to the best of my knowledge and this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

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.