Iowa Department of Human Services

**Request for Prior Authorization**
**LONG-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 long-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 a diagnosis of chronic pain severe enough to require daily, around-the-clock, long-term 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) There is documentation of a previous trial and therapy failure with one preferred long-acting opioid at a maximally tolerated dose, and 5) A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization, and 6) The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website and determine if use of a long-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 7) Patient has been informed of the common adverse effects and serious adverse effects of opioids. 8) Requests for long-acting opioids will only be considered for FDA approved dosing intervals; and 9) 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 long-acting opioid is appropriate for this member; and 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 would be medically contraindicated.**

**Drug Name:**_____ **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: _____

**Document 2 nonopioid pharmacologic therapies** (acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants)

Nonopioid Pharmacologic Trial #1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Nonopioid Pharmacologic Trial #2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

# Request for Prior Authorization-*Continued*
# LONG-ACTING OPIOIDS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

**Document 1 preferred long-acting opioid treatment failure including drug name, strength, exact date ranges and failure reason**:

Preferred Long-Acting Narcotic Trial: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

*Please refer to the methadone dosing guidelines located at www.iadur.org under the Report Archive tab.

**Prescriber review of patient's controlled substances 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

**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: _____

_____

**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:_____

**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: _____

_____

***Attach signed chronic opioid therapy management plan between the prescriber and patient.***

| 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.*