High-Dose Opioids Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004.
Provider Help Desk: 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for use of high-dose opioids ≥ 90 morphine milligram equivalents per day. (See the CDC *Guideline for Prescribing Opioids for Chronic Pain* at **https://www.cdc.gov/drugoverdose/prescribing/guideline.html.**)

Patients undergoing active cancer treatment or end-of-life care will not be subject to the criteria below. Payment will be considered when **all** the following are met:

1. Requests for nonpreferred opioids meet criteria for coverage (see criteria for long-acting opioids and/or short-acting opioids)
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
3. Patient has tried and failed at least two nonpharmacological therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]);
4. Patient has tried and failed at least two non-opioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants)
5. There is documentation demonstrating an appropriate upward titration or an appropriate conversion from other opioid medications

6. Pain was inadequately controlled at the maximum allowed dose without prior authorization for the requested opioid(s)
7. Pain was inadequately controlled by two other chemically distinct preferred long-acting opioids at the maximum allowed dose without prior authorization
8. Chart notes from a recent office visit for pain management are included, documenting the following:
   a) treatment plan, including all therapies to be used concurrently (pharmacologic and nonpharmacologic)
   b) treatment goals
9. Patient has been informed of the risks of high-dose opioid therapy
10. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website and determined that use of high-dose opioid therapy is appropriate for this patient
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
12. A signed chronic opioid therapy management plan between the prescriber and patient dated within 12 months of this request is included
13. The requested dosing interval is no more frequent than the maximum FDA-approved dosing interval.
14. Patient has been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose
15. Patient has been educated on opioid overdose prevention
16. Patient's household members have been educated on the signs of opioid overdose and how to administer naloxone
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
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 6 months with **all** the following:

1. High-dose opioid therapy continues to meet treatment goals, including sustained improvement in pain and function.
2. Patient has not experienced an overdose or other serious adverse event.
3. Patient is not exhibiting warning signs of opioid use disorder.
4. The benefits of opioids continue to outweigh the risks.
5. A documented dose reduction has been attempted at least annually, and the prescriber has determined the dose cannot be reduced at this time.
6. The prescriber has reviewed the patient's use of controlled substances on the Iowa PMP website and determined that continued use of high-dose opioid therapy is appropriate for this patient.
7. Patient will not be using opioids and benzodiazepines concurrently, or a taper plan to discontinue the benzodiazepine must be submitted with subsequent requests.
8. Patient has been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose.
9. Patient has been re-educated on opioid overdose prevention.
10. Patient's household members have been re-educated 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-CM code:**_____

Proceed to prescriber signature for active cancer treatment or end-of-life care diagnoses.

Initial requests:
Document nonpharmacological therapies (such as physical therapy; weight loss; alternative therapies, such as manipulation, massage and acupuncture; or psychological therapies, such as cognitive behavioral therapy [CBT], etc.)
Nonpharmacological treatment trial #1: :_____
Trial dates: _____ Failure reason: _____
Nonpharmacological treatment trial #2: _____
Trial dates:_____ Failure reason:_____

Document two non-opioid 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: _____

Document upward titration or conversion from other opioid medications : _____
Was pain inadequately controlled at the maximum dose allowed without prior authorization for the requested opioid(s)? ☐ No ☐ Yes
Document dose and trial dates: _____

Was pain inadequately controlled by 2 other chemically distinct preferred long-acting opioids at the maximum dose allowed without prior authorization? No ☐ Yes ☐; Document below.
Preferred long-acting narcotic trial #1: Name/dose: _____
Trial dates:_____ Failure reason:_____
☐ Treatment plan, including all therapies to be used concurrently (pharmacologic and nonpharmacological)
☐ Treatment goals

Has the patient been informed of the risks of high-dose opioid therapy? ☐ No ☐ Yes

Has the prescriber reviewed the patient's controlled substance use on the Iowa PMP website: ☐ No ☐ Yes; Date reviewed: _____

Is long-acting opioid use appropriate for the 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 the patient been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose? ☐ No ☐ Yes; Date Rx written: _____

Has the patient been educated on opioid overdose prevention? ☐ No ☐ Yes; Date: _____

Have the patient's household members been educated on the signs of opioid overdose and how to administer naloxone? ☐ No ☐ Yes; Date: _____

Is the patient using opioids and benzodiazepines concurrently? ☐ No ☐ Yes (Provide taper plan to discontinue the benzodiazepine.)

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: _____

Has the patient experienced an overdose or other serious adverse event? ☐ No ☐ Yes

Is the patient exhibiting warning signs of opioid use disorder? ☐ No ☐ Yes

Do the benefits of opioids continue to outweigh the risks? ☐ No ☐ Yes; Date of patient's most recent documented dose reduction: _____

Has prescriber updated review of the patient's controlled substances use on the Iowa PMP website:
☐ No ☐ Yes; Date reviewed: _____

Is the patient using opioids and benzodiazepines concurrently? ☐ No ☐ Yes (Provide taper plan to discontinue the benzodiazepine.)

Has the patient been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose? ☐ No ☐ Yes; Date Rx written: _____

Has the patient been re-educated on opioid overdose prevention? ☐ No ☐ Yes; Date: _____

Have the patient's household members been re-educated on the signs of opioid overdose and how to administer naloxone? ☐ No ☐ Yes; Date: _____

Attach a signed chronic opioid therapy management plan between the prescriber and patient dated **within 12 months of this request**.

9. Physician signature

Prescriber or authorized signature	Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.