https://providers.amerigroup.com

Long-Acting 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 (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.
2. Patient has tried and failed at least two nonpharmacologic therapies.
3. Patient has tried and failed at least two nonopioid pharmacologic therapies.
4. There is documentation of a previous trial and therapy failure with one preferred long-acting opioid at a maximally tolerated dose.
5. A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization.
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.
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.
9. For patients taking concurrent benzodiazepines, the prescriber must document the following:
    a. Risks of using opioids and benzodiazepines concurrently have been discussed with the patient.
    b. Why concurrent use is medically necessary.
    c. A plan to taper the benzodiazepine 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.

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.
3. For patients taking concurrent benzodiazepines, the prescriber must document the following:
    a. Risks of using opioids and benzodiazepines concurrently have been discussed with the patient.
    b. Why concurrent use is medically necessary.
    c. A plan to taper the benzodiazepine if appropriate. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.
    d. Nonpharmacological therapies.

Document nonpharmacologic 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.

Nonpharmacological treatment trial #1: _____
Trial dates: _____ Failure reason: _____
Nonpharmacological 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: _____

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: ☐ Yes ☐ No
Date reviewed: _____

Is long-acting opioid use appropriate for patient based on PMP review and patient's risk for opioid addiction, abuse and misuse?
☐ Yes ☐ No

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? ☐ Yes ☐ No

Patients taking concurrent benzodiazepines
Have the risks of using opioids and benzodiazepines concurrently been discussed with the patient? ☐ Yes ☐ No
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? ☐ Yes ☐ No
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.

Attach lab results and other documentation as necessary.

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.