Amerigroup
District of Columbia

Medicaid

Provider update

Pharmacy Analgesic Opioid Prior Authorization Form

Instructions:

1. Complete this form in its entirety. Any incomplete sections will result in a delay in processing. PA request can also be submitted electronically at www.covermymeds.com or www.availity.com.
2. We review requests for prior authorization (PA) based on medical necessity only. If we approve the request, payment is still subject to all general conditions of Amerigroup District of Columbia, Inc., including current enrollee eligibility, other insurance, and program restrictions. We will notify the provider and the enrollee's pharmacy of our decision.
3. To help us expedite your authorization requests, please fax all the information required on this form to 844-487-9292 (retail) or 844-487-9294 (medical injectables).
4. Allow us at least 24 hours to review this request. If you have questions regarding a PA request, call us at **Phone Number**, Monday through Friday, 8 a.m. to 6 p.m. Eastern.
5. The pharmacy is authorized to dispense up to a 72-hour supply while awaiting the outcome of this request. Please contact the enrollee's pharmacy.
6. Access our website at **www.provider.amerigroup.com/dc** to view the *Preferred Drug List*.
7. An ICD/diagnosis code is required for all requests. An HCPCS billing code is required for all medical injectable/oncology requests. If the billing facility is different from the requesting physician, the billing facility information will need to be completed.

Enrollee information

Last name	First name	MI	Amerigroup ID #	Date of birth	Sex ☐ F☐ M
Enrollee's place of residence: ☐ Home ☐ Nursing facility ☐ Long-term care facility Administration site: ☐ Home ☐ Office ☐ Outpatient facility			Height	Weight	

Medication information (Please use a separate form for each medication request.)

Drug name and strength requested	SIG (dose, frequency, and duration)	Quantity
Diagnosis and/or indication	ICD code	HCPCS billing code

PA type

Approval duration:
☐ New prescription — approved for three months
☐ Continuation therapy (enrollee has been taking this medication) — approved for six months

Request type:
☐ Quantity limit ☐ High dose (≥90 cumulative MED/day)
☐ Long-acting opioid ☐ Nonpreferred
☐ Methadone for pain ☐ Fentanyl ☐ Other_____

Approval criteria (Please check all boxes that apply.)

Note: Any areas not filled out are considered not applicable to your enrollee and may affect the outcome of this request.

Y	*N*	*Criteria*
Section A. Enrollee meeting one of the following is not required to meet the PA criteria unless the requested agent is nonpreferred. For requests for nonpreferred long-acting agents, please proceed to Section F. For requests for nonpreferred short-acting agents, please proceed to Section G.		
☐	☐	Enrollee has a diagnosis of cancer-related pain and/or is actively undergoing cancer therapy. If yes, please indicate specific diagnosis: _____
☐	☐	Enrollee has a diagnosis of terminal illness and is receiving palliative/end-of-life care. If yes, please indicate specific diagnosis: _____
☐	☐	Enrollee has a diagnosis of sickle cell disease.
☐	☐	Enrollee is currently receiving care at a long-term care facility.
Section B. All request types for enrollee not meeting one of the criteria under Section A		
☐	☐	Prescriber has reviewed controlled dangerous substance (CDS) prescriptions in Prescription Drug Monitoring Program (PDMP) (CRISP).
☐	☐	Enrollee has had/will have random urine drug screens before and during treatment.
☐	☐	Naloxone prescription was provided or offered to enrollee/enrollee's household.
☐	☐	Enrollee-prescriber pain management/opioid treatment agreement/contract signed and in medical record.
☐	☐	Prescriber has certified the benefits of opioid treatment for the enrollee outweigh the risks of treatment.
Section C. All requests for long-acting agents		
☐	☐	Enrollee has a diagnosis of pain severe enough to require daily, around-the-clock, long-term opioid treatment. If yes, please indicate specific diagnosis: _____
☐	☐	Enrollee has had an inadequate response to alternative treatment options such as (but not limited to) non-opioid analgesics and immediate-release opioids.
☐	☐	Alternative treatment options would otherwise be inadequate to provide sufficient management of pain.
☐	☐	Enrollee has contraindications to non-opioid analgesics (such as NSAID use in a enrollee with active ulcer condition/gastrointestinal bleeding/renal failure).
☐	☐	Enrollee is 18 years of age or older.

☐	☐	Prescriber has consulted with the enrollee regarding risks of opioid therapy.
☐	☐	Clear treatment goals have been defined and outlined as part of overall plan.
☐	☐	Requested medication is being used as an as-needed analgesic.
☐	☐	Enrollee has one of the following conditions: significant respiratory depression, acute or severe bronchial asthma or hypercarbia, or known or suspected paralytic ileus.
Section D. Additional for requests for initial therapy		
☐	☐	Enrollee is currently taking a short-acting analgesic (for example, use of opioid analgesia as an inpatient for post-surgical pain).
☐	☐	Enrollee is transitioning from one long-acting opioid analgesic to another long-acting opioid analgesic.
Section E. Additional for requests for continuation of therapy		
☐	☐	Long-acting opioid therapy has provided meaningful improvement in pain and/or function compared to baseline.
Section F. Additional for requests for nonpreferred long-acting agents *Preferred* long-acting agents are morphine sulfate ER tablets (generic MS Contin), methadone and fentanyl patch (generic Duragesic).		
☐	☐	Enrollee has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response or intolerance to two preferred long-acting agents.
☐	☐	Enrollee has completed titration and is already maintained on a stable dose of the requested drug.
☐	☐	Preferred long-acting opioids are unacceptable due to concomitant clinical situations such as (but not limited to) known hypersensitivity to any ingredient not also in the requested nonpreferred agent.
		Please describe medical necessity for nonpreferred agents: _____ _____ _____
Section G. Additional for requests for nonpreferred short-acting agents *Nonpreferred* short-acting agents are all brand products, tapentadol (generic Nucynta) and oxymorphone (generic Opana).		
☐	☐	Enrollee has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response or intolerance to one preferred short-acting agent.
		Please describe medical necessity for nonpreferred agents: _____ _____ _____

Prescriber information

Last name	First name	MI	NPI (required)	DEA/license no.
Address where service was rendered			City	State
ZIP code	Telephone number		Fax number	
Office contact name			Contact direct phone number	

Billing facility information

Name		NPI /tax ID (required)	DEA/license no.
Address		City	State
ZIP code	Telephone number	Fax number	Office contact name

Pharmacy information

Name	Pharmacy NPI	Telephone number	Fax number

Signature

I certify the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material may be subject to civil or criminal liability.

Prescriber signature (or authorized representative) Date