

**Request for Prior Authorization
High Dose Opioids**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

3. Patient is not exhibiting warning signs of opioid use disorder; and
4. The benefits of opioids continue to outweigh the risks; and
5. A documented dose reduction has been attempted at least annually, and the prescriber has determined the dose cannot be reduced at this time; and
6. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website and determined that continued use of high-dose opioid therapy is appropriate for this patient; and
7. Patient will not be using opioids and benzodiazepines concurrently or a taper plan to discontinue the benzodiazepine must be submitted with subsequent requests; and
8. Patient has been provided a prescription for a preferred naloxone product for the emergency treatment of an opioid overdose; and
9. Patient has been reeducated on opioid overdose prevention; and
10. Patient's household members have been reeducated 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 code:** _____

* Proceed to Prescriber Signature for active cancer treatment or end of life care diagnoses.

Initial Requests:

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 two 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 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 two 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: _____

Preferred long-acting narcotic trial #2: Name/dose: _____

Trial dates: _____ Failure reason: _____

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Attach notes from a recent office visit for pain management documenting both of the following:

- Treatment plan, including all therapies to be used concurrently (pharmacologic and nonpharmacologic)
- Treatment goals

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

Prescriber review of patient's controlled substance 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

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

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

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

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

Is 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 patient experienced an overdose or other serious adverse event? No Yes

Is 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: _____

Updated prescriber review of patient's controlled substances use on the Iowa PMP website: No Yes

Date reviewed: _____

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

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

Has patient been reeducated on opioid overdose prevention? No Yes Date: _____

Has patient's household members been reeducated 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**.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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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.