



Instructions: Completion of this prior authorization (PA) form is required for timely processing of the prescription. Complete and fax this form back to Kaiser Permanente within 24 hours at fax: 1-866-331-2104. For questions or concerns, call 1-866-331-2103. The

KPMAS MD Medicaid Formulary can be found at:

https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_md_health_choice_formulary.pdf

CDC Guidelines for Opioid prescribing for Chronic Pain: OPIOIDS ARE NOT RECOMMENDED AS FIRST-LINE TREATMENT FOR CHRONIC PAIN. Please see http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm for additional information.

Prior Authorization is required for:

- 1) All Long-acting Opioids
2) Any opioid (short- and long-acting) exceeding Morphine Milligram Equivalents (MME) dose of 90 mg/day

1-Patient Information

Patient Name: Kaiser Medical ID#:
Date of Birth: Gender: Male Female Phone #:

2-Provider Information

Provider Name: Provider NPI:
Provider Address: Phone Fax
Specialty: Oncologist Hematology Chronic Pain Specialist Palliative Care Other:
Please check the box that applies:
Standard Review (72 hours)
Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.
Provider Signature

3-Important Exclusion Criteria

Important: The remainder of this prior authorization form does not need to be completed for patients receiving opioid due to the following conditions or care plans:

- Active Cancer Treatment I attest this patient has active cancer. Yes No
Sickle Cell Disease I attest this patient has sickle cell disease. Yes No
Hospice or Palliative Care I attest this patient is receiving hospice or palliative care. Yes No
Pregnancy Status I attest this patient is pregnant. Yes No

Provider Signature Date
(If Yes, please sign and submit, no further information required)

*If the above conditions do not apply, please continue to section 4-9.

4-Alternative Therapy to Schedule II Opioid

Alternative therapy to Schedule II opioid drugs. Complete list of KPMAS MD Medicaid formulary can be found at:

https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_md_health_choice_formulary.pdf

Preferred Alternative Products: NSAIDs topical and oral; SNRI; Tricyclic Antidepressants; Gabapentin CAPS; Baclofen, Capsaicin topical cream 0.025%

1. Has patient tried and failed any of the above non-opioid therapy? Yes No

If yes, document therapy tried _____

If no, document clinical reason _____

5- Prescription Drug Monitoring Program (PDMP)

2. **Attestation:** Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP) on the date of this request to determine whether the patient is receiving dangerous opioid dosages or combinations (such as opioids and benzodiazepines) that put him or her at high risk for fatal overdose. Yes No

PDMP FAQ and Registration Website: <http://crisphealth.org/services/prescription-drug-monitoring-program-pdmp/pdmp-registration/>

CRISP Log-in: <https://portal.crisphealth.org/MirthSignOn-idp/sso>

3. Document the **fill date** of the patient's **last opioid** Rx (if applicable): _____ N/A

4. Document the **fill date** for the patient's **last benzo** Rx (if applicable): _____ N/A

6- Therapy Prescribed

5. Please indicate the patient's diagnosis for taking an opioid:

Post-operative pain Acute pain (pain lasting <90 days) Chronic pain (pain lasting > 90 days)

Drug Name/Form: _____ Strength: _____ Qty Requested: _____

Directions: _____ Length of Therapy: _____ Total Daily Dose _____

Total Daily MME: _____ If > 90 MME provide clinical rationale _____

Drug Name/Form: _____ Strength: _____ Qty Requested: _____

Directions: _____ Length of Therapy: _____ Total Daily Dose _____

Total Daily MME: _____ If > 90 MME provide clinical rationale _____

6. Does the patient's total MME exceed 90 mg when including this prescription? Yes No. If yes, please provide clinical rationale _____

Opioid Dose Calculator: <http://agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm>

7- Substance Use Disorder Screening

7. Prior to prescribing any controlled substance, providers should use a standardized tool such as SBIRT (Screening Brief Intervention and Referral to Treatment: <http://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs>) to identify any type of or history of substance use disorder. Yes No

Caution should be used when prescribing opioids to any patients with any type of or history of substance use disorder. Identified patients should be referred to a substance use or behavioral health treatment program. **Information and resources regarding referral are available through Beacon Health Options:** http://maryland.beaconhealthoptions.com/med_hc_professionals.html

8- Additional Required Information

8. **Attestation:** Prescriber has established a treatment plan (including therapy goals and benefits vs. harm) that has been reviewed with the patient. A **SIGNED** Provider-Patient contract has been uploaded into the medical record of the patient.

Sample Physician/Patient Agreement: <https://www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForms.pdf>

Yes **No.** If no, please explain _____

9. **Attestation:** Prescriber provided or considered/offered a Naloxone prescription to the patient/patient's household.

Yes **No.** If no, please explain _____

Providers should consider that patients with a history of overdose, history of substance use disorder, concomitant use of benzodiazepines, or taking > 50 MME/day are at increased risk of overdose, according to the CDC Guidelines for prescribing Opioids for Chronic Pain.

10. **Attestation:** Patient has had or will have random urine drug screens (UDS). A copy of the UDS is attached.

Yes **No.** If no, please explain _____

9- Provider Sign off

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Physician Signature _____

Date: _____

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this tele copied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility