



**Instructions:** Completion of this prior approval 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 VA Medicaid Formulary** can be found at: [https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid\\_medicaid.pdf](https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_medicaid.pdf)

Virginia Medicaid requires Prior Authorization when a Benzodiazepine is prescribed while patient is taking an Opioid medication to ensure patient safety according to CDC Guideline and FDA Black Box Warning when opioid-benzodiazepine are concurrently used.

**FDA Black Box Warning:** Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing for use in patients for whom alternative treatment options are inadequate; limit dosages and durations to the minimum required; and follow patients for signs and symptoms of respiratory depression and sedation.

**Intervention:** Reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate. Limit dosages and durations to the minimum required. Follow patients closely for signs of respiratory depression and sedation.

### 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  Psychiatrist  Substance Use Disorder  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- Therapy Prescribed

Drug Name/Form: \_\_\_\_\_ Strength: \_\_\_\_\_ Qty Requested: \_\_\_\_\_  
Directions: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

### 4-Medical Information

1. Is the request for initial or continuing therapy?  
 Initial  Continuing: please provide the start date \_\_\_\_\_
2. Please indicate the patient's diagnosis for taking a benzodiazepine below:  
 Acute alcohol withdrawal  
 Adjunct for relief of skeletal muscle spasms  
 Anxiety  
 Convulsive disorders
3. Please indicate the patient's diagnosis for taking an opioid below:  
 Active Cancer Pain  
 Hospice care/Palliative care  
 Chronic, non-cancer pain  
 Acute Pain

### 5-Prescription Monitoring Program (PMP)

4. The prescriber has checked the PMP on the date of this request to determine whether the patient is receiving opioid dosages or dangerous combinations (such as opioids and benzodiazepines) that put him or her at high risk for fatal overdose. PMP website: <https://www.pmp.dhp.virginia.gov/VAPMPWebCenter/login.aspx>  
 Yes  No
5. Document the **fill date of the patient's last opioid Rx**: \_\_\_\_\_
6. Document the **fill date for the patient's last benzo Rx**: \_\_\_\_\_
7. Does the prescriber attest that he/she will be managing the patient's therapy long term, and that they have read the FDA black box warning on prescribing of Opioids and Benzodiazepines and the dangers involved, and that therapy is medically necessary for this patient?  
 Yes  No
8. If **no** to any of the above, please explain and provide clinical rationale: \_\_\_\_\_  
\_\_\_\_\_

### 6- Provider Sign off

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

Physician Signature \_\_\_\_\_

Date: \_\_\_\_\_

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