Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Pharmacy Benefits Prior Authorization Help Desk
Short-acting, Long-acting, Methadone Opioids Prior Authorization (PA)

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 VA Medicaid Formulary can be found at:**
https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_medicaid.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 Short-Acting Opioid prescribed for > 7 days or two (2) 7 day supplies in a in a 60 day period. *The Virginia BOM Regulations limit the treatment of acute pain with opioids to 7 days and post-op pain to no more than 14 days.***
3) **Any cumulative opioid prescription exceeding 120 morphine milligram equivalents (MME) per 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

1) Does the prescriber attest that the patient has intractable pain from active cancer, end-of-life? □ **Yes** □ **No**
If Yes, please select what applies sign and submit the form, no further information is required. □ **Active cancer** □ **Hospice** □ **Palliative care**

2) Is the patient on remission from cancer, and prescriber is safely weaning patient off of opioids with a tapering plan? □ **Yes** □ **No**
If Yes, please sign and submit, no further information is required

3) Is the patient on long-term care facility? □ **Yes** □ **No** If Yes, please sign and submit, no further information is required
Provider Signature_____

4-Alternative Therapy to Schedule II Opioid

Alternative therapy to Schedule II opioid drugs. Complete list of KPMAS VA Medicaid formulary can be found at:
https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_medicaid.pdf
Preferred Alternative Products: **NSAIDs topical and oral; SNRI; Tricyclic Antidepressants; Gabapentin CAPS; Baclofen**

5- Therapy Prescribed

This REQUEST is for: □ Short-Acting Opioid (SAO) □ Long-Acting Opioid (LAO) □ Methadone for pain (check all that apply)

Drug Name/Form: _____Strength:_____ Qty Requested:_____
Directions:_____ Length of Therapy:_____ Total Daily Dose_____
Total Daily MME:_____ If > 90 mg MME provide clinical rationale_____

Drug Name/Form: _____Strength:_____ Qty Requested:_____
Directions:_____ Length of Therapy:_____ Total Daily Dose_____
Total Daily MME:_____ If > 90 mg MME provide clinical rationale_____

Cumulative Total Daily MME dose calculated from PMP https://virginia.pmpaware.net/login**:** _____ MME

If patient's Active Daily MME greater than or equal to 120, does the prescriber attest that he/she will be managing the patient's opioid therapy long term, has reviewed the Virginia BOM Regulations for Opioid Prescribing, has prescribed naloxone, and acknowledges the warnings associated with high dose opioid therapy including fatal overdose, and that therapy is medically necessary for this patient? **□ Yes □ No**
Provider Signature_____

6-Medical Information

1. Is this medication being used to treat Acute Pain (pain lasting < 90 days) **□ Yes □ No** Post-operative pain **□ Yes □ No** or Sickle Cell Disease **□ Yes □ No. If yes to any of the conditions, complete questions 4-10, sign and submit the form**

2. Is this medication being used to treat Chronic Pain (pain lasting > 90 days) **□ Yes □ No If yes, complete the rest of this form**

3. **If this order is for Methadone for chronic pain management,** provide evidence that at least 2 or more preferred long-acting opioids have been tried and failed and complete the rest of the form? **□ Yes □ No**

Drug 1	Strength	Length of Trial	Reason for discontinuation of the drug
Drug 2	**Strength**	**Length of Trial**	**Reason for discontinuation of the drug**

4. Has the patient tried any of the following non-opioid therapies that don't require PA? (check all that apply)
□ Baclofen □ NSAID (oral) □ Diclofenac gel □ Gabapentin □ Duloxetine □ Carbamazepine □ Capsaicin Gel□ Tricyclic Antidepressants

5. If requesting a non-preferred opioid product, has the patient failed an adequate trial of preferred product? **□ Yes □ No**
If yes, list below and provide clinical evidence that the preferred agent(s) will not provide adequate benefit_____
_____

Drug 1	Strength	Length of Trial	Reason for discontinuation of the drug
Drug 2	**Strength**	**Length of Trial**	**Reason for discontinuation of the drug**

6. If patient is female between 18-45 years old, has the prescriber discussed risk of neonatal abstinence syndrome and provided counseling on contraceptive options? **□ Yes □ No □ N/A**

7-Prescription Monitoring Program (PMP)

7. 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**

8. Document the **fill date of the patient's last opioid Rx:** _____

9. Document the **fill date for the patient's last benzo Rx:** _____ N/A □

If benzodiazepine filled in past 30 days, does the prescriber attest that he/she has counseled the patient on the FDA black box warning on the dangers of prescribing Opioids and Benzodiazepines including fatal overdose, has documented that the therapy is medically necessary, and has recorded a tapering plan to achieve the lowest possible effective doses of both opioids and benzodiazepines per the Board of Medicine Opioid Prescribing Regulations? □ **Yes** □ **No**

10. Has naloxone been prescribed for patients with risk factors of prior overdose, substance use disorder, opioid doses in excess of 120 MME/day, or concomitant benzodiazepine? □ **Yes** □ **No** □ **N/A**

8- Treatment Plan

11**. For Chronic Pain**: Prescriber attests that a treatment plan with goals that addresses benefits and harm has been established with the patient and the following bullets are included and there is a **SIGNED AGREEMENT** with the patient. This will be reviewed with the patient within 1 to 4 weeks of starting opioid therapy for chronic pain, with dose escalation and is reviewed every 3 months or more frequently. □ **Yes** □ **No**
(Sample Physician/Patient Agreement: www.drugabuse.gov/sites/default/files/files/samplepatientagreementforms.pdf)
12. **For Chronic Pain**: The prescriber has ordered and reviewed a urine drug screen (UDS) or serum medication level prior to initiating treatment with short or long-acting opioids? □ **Yes** □ **No**

13. **For Chronic Pain** PA renewals, has the prescriber ordered and reviewed a urine drug screen (UDS) or serum medication level at least every 3 months for the first year of treatment and at least every 6 months thereafter to ensure adherence? □ **Yes** □ **No** □ **N/A**

14. If patient exhibits any signs of opioids use disorder, please consider referring the patient to a substance use disorder treatment program? □ **Yes** □ **No**

15. If **no** to any of the above, please explain or provide clinical rationale: _____

_____

9- Provider Sign off

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

Physician Signature_____	**Date:**