Reset Form Print Form

Prior Authorization Form
Long-Acting Narcotics

Fax this form to: 1-800-424-3260

A fax cover sheet is not required.

Instructions: Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). **Information contained in this form is Protected Health Information under HIPAA**.

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Member's Identification Number:

Date of Birth: __ __ – __ __ – __ __ __ __

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

National Provider Identifier (NPI) Number:

DEA Number:

Office Phone Number: __ __ __ – __ __ __ – __ __ __ __

Office Fax Number: __ __ __ – __ __ __ – __ __ __ __

CLINICAL CRITERIA

1. What medication is being requested? _____
2. What is the diagnosis for the medication? _____

For diagnoses of cancer, palliative/end-of-life care, or hospice – NO ADDITIONAL INFORMATION IS NEEDED

3. What is the underlying condition causing the member's pain?

   _____
4. Does the member require around-the-clock pain management?
   ☐ Yes ☐ No
5. Is the member inadequately controlled on short acting opioid medication?
   ☐ Yes ☐ No
6. Does the member have moderate to severe pain?
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

7. Has the member had chronic pain for at least 3 months?
   ☐ Yes ☐ No
8. Did the member's pain fail to respond to non-pharmacological treatment (i.e., physical therapy, pain psychology, alternative treatments)?
   ☐ Yes ☐ No
9. Did the member's pain fail to respond to non-opioid analgesic treatment (i.e., NSAIDs, acetaminophen, gabapentin, lidocaine patch, muscle relaxers)?
   ☐ Yes ☐ No
10. Does the member's pain significantly impair physical functioning (i.e., activity of daily living [ADLs], sleep, work)?
    ☐ Yes ☐ No
11. Does the prescriber monitor the state Prescription Monitoring Program (PMP) prior to prescribing any medications?
    ☐ Yes ☐ No
    If **No**, provide details:

    _____
12. Is the member currently undergoing active treatment for opioid addiction?
    ☐ Yes ☐ No
13. Does the member have a documented history of opioid addiction or abuse?
    ☐ Yes ☐ No
14. Does the prescriber have a treatment plan in place that defines the goals of therapy, harms of opioid use, and the expectations of using a single opioid prescriber and/or regular dispensing pharmacy?
    ☐ Yes ☐ No
15. When was the last urine drug screen done? _____
    If a urine drug screen is not done, provide rationale for not completing one:

    _____
16. Is the member being prescribed a naloxone kit?
    ☐ Yes ☐ No
17. Has the member been counseled on the risks of overdose, addiction, and drug diversion?
    ☐ Yes ☐ No
18. What other non-opioid pain treatments are being used by the member (e.g., physical therapy)?
    ☐ Yes ☐ No

    List any that apply: _____
19. Is the member concurrently taking a benzodiazepine or sedative hypnotics?
    ☐ Yes ☐ No
    If **Yes,** have they been counseled on the increased risks of side effects?
    ☐ Yes ☐ No

(Form continued on next page.)

 MHID: MRXCOM06_01

Member's Last Name:

Member's First Name:

20. What concurrent pain treatments are being used?

_____

21. Is the member receiving or is the member scheduled to receive counseling for weaning opioids?
    ☐ Yes ☐ No
22. Is the member undergoing active dose titration?
    ☐ Yes ☐ No
23. Is the member stabilized for a chronic condition that requires ongoing opioid therapy?
    ☐ Yes ☐ No

For ConZip® (tramadol ER) (in addition to above questions):

1. Does the member have a diagnosis of seizure disorder?
   ☐ Yes ☐ No
2. Will the member be taking any other tramadol products concurrently?
   ☐ Yes ☐ No
   If **Yes**, list products and total daily dose:

   _____

For Butrans® (in addition to above questions):

1. Is the medication being used for acute or post-operative pain?
   ☐ Yes ☐ No
2. Is the member taking any other opioid agonist?
   ☐ Yes ☐ No
   If **Yes**, list opioid agonists:

   _____
3. Does the member actively abuse alcohol?
   ☐ Yes ☐ No

For Belbuca® (in addition to above questions):

1. Is the member taking any other short-acting opioid for breakthrough pain or titration?
   ☐ Yes ☐ No

   If **Yes,** does the provider attest that withdrawal symptoms are known to occur with mixed opiate agonist/antagonist use?
   ☐ Yes ☐ No
2. Does the member actively abuse alcohol?
   ☐ Yes ☐ No

(Form continued on next page.)

 MHID: MRXCOM06_01

Member's Last Name:

Member's First Name:

For Methadone (in addition to above questions):

1. **For Initiation:** Has the member had an electrocardiogram (EKG) with normal QTc within 30 days prior to initiation of the medication?
   ☐ Yes ☐ No
   If **No**, provide rationale:

   _____

2. **For Renewal:** Has the member had an EKG with QTc < 450 within 30 days prior to this renewal request?
   ☐ Yes ☐ No
   If **No**, provide rationale:

   _____

For Nucynta® ER (in addition to above questions):

1. For **severe pain** requiring daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate, has the member failed any of the following? (Check all that apply.)
   ☐ Xtampza® ER ☐ hydromorphone HCl ☐ morphine sulfate ER
   ☐ oxycodone ER ☐ oxymorphone HCl ER ☐ tramadol ER
2. For **severe neuropathic pain associated with diabetic peripheral neuropathy**, has the member failed any of the following: anticonvulsants, SNRIs, TCAs, or a tramadol-containing agent?
   ☐ Yes ☐ No
   List agents tried:

   _____

Note: If approved, compliance with therapy is required. Authorizations will be terminated for members who are noncompliant with therapy.

_____ _____

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to: 1-800-424-3260

Mail requests to:
Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
4801 E. Washington Street
Phoenix, AZ 85034
Phone: 1-800-424-3312

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