Reset Form Print Form

Prior Authorization Form
Short-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? _____
3. What is the underlying condition causing the member's pain?

   _____
4. What is the quantity requested and directions for use?

   _____
5. Does the member require around-the-clock pain management?

   ☐ Yes ☐ No
6. Does the member have moderate to severe pain?

   ☐ Yes ☐ No
7. Does the member have a diagnosis of acute pain?

   ☐ Yes ☐ No

(Form continued on next page.)

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

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

8. What is the anticipated treatment duration? _____
   List any non-pharmacological treatment the member is currently using:
   _____
9. Is the member's pain non-responsive or inadequately responsive to non-pharmacological treatment (i.e., physical therapy, pain psychology, alternative treatments)?
   ☐ Yes ☐ No
10. Is the member's pain non-responsive or inadequately responsive to non-opioid analgesic treatment (i.e., nonsteroidal anti-inflammatory drugs [NSAIDs], acetaminophen, gabapentin, lidocaine patch, muscle relaxers)?
    ☐ Yes ☐ No
11. Is the member using any non-opioid medications?
    ☐ Yes ☐ No
    If **Yes**, list any non-opioid medications the member is currently using:
    _____
12. Does the member's pain significantly impair physical functioning (i.e., activity of daily living [ADLs], sleep, work)?
    ☐ Yes ☐ No
13. Does the physician attest to monitoring the state Prescription Monitoring Program (PMP) prior to prescribing any medications (if available in state)?
    ☐ Yes ☐ No
14. Is the member currently undergoing active treatment for opioid addiction?
    ☐ Yes ☐ No
15. Does the member have a documented history of opioid addiction or abuse?
    ☐ Yes ☐ No

For Chronic Pain:

16. Does the physician have a treatment plan in place with the member that addresses the benefits and harm of opioid use, expectations and goals of treatment, and stipulations for continued treatment (i.e., functional improvement, a single opioid prescriber and/or regular dispensing pharmacy)?
    ☐ Yes ☐ No
17. Does the physician attests to completing an annual urine drug screen?
    ☐ Yes ☐ No
    If **Yes**, when was the last drug screen performed?:
    _____

(Form continued on next page.)

 MHID: MRXCOM08_01

Member's Last Name:

Member's First Name:

For Doses > 50 Morphine Milligram Equivalent (MME) – for Short-Acting Narcotics ONLY:

1. What is the justification for why a higher dose is necessary and a lower dose will be inadequate?

   _____

2. Has a pain specialist been consulted?
   ☐ Yes ☐ No
3. Has the member been counseled on the risks of overdose, addiction, and/or drug diversion?
   ☐ Yes ☐ No
4. Is the member on a benzodiazepine or sedative hypnotic?
   ☐ Yes ☐ No
   If **Yes**, provide justification for concomitant use with an opioid:

   _____

5. Is a naloxone kit being prescribed?
   ☐ Yes ☐ No
6. Is the member receiving or is the member scheduled to receive counseling for weaning opioids, undergoing active dose titration, or stabilized for a chronic condition that requires ongoing therapy?
   ☐ Yes ☐ No

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

1. Does the member have a diagnosis of seizure disorder?
   ☐ Yes ☐ No
2. Is the member being treated for chronic pain?
   ☐ Yes ☐ No

For Butrans® (in addition to above):

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

   _____

4. Does the member actively abuse alcohol?
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

For Belbuca® (in addition to above):

1. Is the member taking any other opioid agonist?
   ☐ Yes ☐ No
   If **Yes**, list the opioid agonist:

   _____

2. Does the member actively abuse alcohol?
   ☐ Yes ☐ No

For Methadone (in addition to above):

1. Has the member had an electrocardiogram (EKG) with normal QTc within 30 days prior to initiation of the medication?
   ☐ Yes ☐ No

   For Renewal:

2. Has the member had an EKG with QTc < 450 within 30 days prior to renewal request?
   ☐ Yes ☐ No

For Nucynta® ER (in addition to above):

For Severe Pain:

1. Has the member failed two of the following: Embeda® ER, hydromorphone ER, Hysingla® ER, morphine sulfate ER, oxycodone ER, OxyContin®, oxymorphone ER or tramadol ER?
   ☐ Yes ☐ No
   List agents tried:

   _____

For Severe Neuropathic Pain Associated with Diabetic Peripheral Neuropathy:

2. 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.

(Form continued on next page.)

Member's Last Name:

Member's First Name:

_____ _____

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.
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Phoenix, AZ 85034
Phone: 1-800-424-3312

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