

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:

Grid for Member's Last Name

Member's First Name:

Grid for Member's First Name

Member's Identification Number:

Grid for Member's Identification Number

Date of Birth:

Grid for Date of Birth

PRESCRIBER INFORMATION

Prescriber's Last Name:

Grid for Prescriber's Last Name

Prescriber's First Name:

Grid for Prescriber's First Name

National Provider Identifier (NPI) Number:

Grid for NPI Number

DEA Number:

Grid for DEA Number

Office Phone Number:

Grid for Office Phone Number

Office Fax Number:

Grid for 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?
6. Does the member have moderate to severe pain?
7. Does the member have a diagnosis of acute pain?

(Form continued on next page.)

Member's Last Name:

Member's First Name:

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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 attest to completing an annual urine drug screen?  
 Yes     No  
If **Yes**, when was the last drug screen performed?:

\_\_\_\_\_

*(Form continued on next page.)*

Member's Last Name:

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Member's First Name:

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**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?

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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:

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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:

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4. Does the member actively abuse alcohol?

Yes     No

*(Form continued on next page.)*

Member's Last Name:

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Member's First Name:

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**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

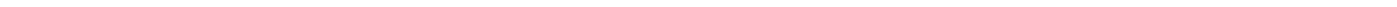
**For Nucynta® ER (in addition to above):**

**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.)*

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Member's First Name:

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**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