Prior Authorization Form

Long-Acting Narcotics

Access this PA form at https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_Long_Acting_Opioid.pdf

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Member Information

LAST NAME: **FIRST NAME:**

ID NUMBER: **DATE OF BIRTH:** – –

Prescriber Information

LAST NAME: **FIRST NAME:**

OFFICE ADDRESS:

CITY: **STATE:** **ZIP:**

NPI NUMBER: **DEA NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

Requested Long-Acting Narcotics	
Preferred	**Non-Preferred**
☐ fentanyl patch (generic for Duragesic®)	☐ SPECIFY: _____
☐ Kadian®	
☐ morphine sulfate SA (generic for MS Contin® & Oramorph®)	

STRENGTH: **DIRECTIONS:** **QUANTITY REQUESTED:**

TOTAL DAILY DOSE:

***NOTE**: The use of opioid analgesics during pregnancy has been associated with neonatal abstinence syndrome.*

**** If requesting a total daily dose exceeding the threshold listed in the tables below, complete Questions 1–11 under Clinical Criteria Documentation along with Questions 12 – 15 under Narcotic Monitoring Information. Otherwise, complete Questions 1-11, then skip to the Authorized Prescriber Signature section at the bottom of the form.*

Drug	Daily Dosage Threshold
Avinza®/morphine ER capsules	180 mg/day
Butrans®	20 mcg/hr: 4 patches per 28 days
Conzip®	300 mg/day
Duragesic® / fentanyl patch	75 mcg/hr: 10 patches per month; **OR**
	100 mcg/hr: 10 patches per month
Exalgo®	32 mg/day
Kadian®/morphine sulfate SR 24 hr	200 mg/day

Drug	Daily Dosage Threshold
Methadose®/ Dolophine®/methadone	40 mg/day
MS Contin®/ Oramorph SR® / morphine sulfate SA	200 mg/day
Nucynta® ER	500 mg/day
Opana® ER/ oxymorphone SR	80 mg/day
Oxycontin®/oxycodone SR	160 mg/day
Zohydro® ER	100 mg/day

*Continued on next page. Signature **MUST** be submitted on page 3.*

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PATIENT NAME: | | | | | | | | | | | | | **DATE OF BIRTH:** | | – | | | – | | | | |

Clinical Criteria Documentation *****Do **not** include documentation that is not requested on this form*****

1. Diagnosis (please check all that apply):

☐ Cancer pain ☐ Sickle cell disease ☐ HIV/AIDS ☐ Other: _____

☐ Chronic back pain ☐ Fibromyalgia ☐ Hospice patient (specify and list ICD-9)

INITIAL DATE OF DIAGNOSIS: _____ **DATE NARCOTICS INITIATED FOR DIAGNOSIS:** _____

2. Does the patient have inability to swallow or absorb PO medications? ☐ Yes ☐ No

3. Will this request be utilized for a dose titration? ☐ Yes ☐ No

4. Has the patient been on another long acting-acting narcotic within the last 30 days? ☐ Yes ☐ No

IF YES, has this medication been discontinued? ☐ Yes ☐ No (please provide reason)

_____

5. Does this patient exhibit any of the following characteristics or behaviors? ☐ Yes (check all that apply) ☐ No

☐ History of addiction to the requested drug ☐ Frequent requests for early refills ☐ Frequent requests for odd quantities

☐ Frequent reports of lost or stolen tablets ☐ Requests for short term or PRN use of long-acting narcotics

☐ History of parenteral substance abuse ☐ Evidence of diversion

Please explain any of the above check boxes: _____

_____

6. Document most recent date the provider checked the Tennessee Controlled Substance Database for this patient: ____/____/____

7. Is the patient currently a resident in a long-term care facility? ☐ Yes ☐ No

IF YES, what is the name of the facility? _____

8. For Butrans requests only: What is the proposed tapering schedule for other opioid analgesics prior to initiation of Butrans?

_____

For female patients between the ages of 18–45, please complete questions 9–11.

9. **The use of opioid analgesics during pregnancy has been associated with neonatal abstinence syndrome** Has this patient been counseled regarding the risks of becoming pregnant while receiving this medication, including the risk of neonatal abstinence syndrome? ☐ Yes ☐ No

10. Is this patient currently utilizing a form of contraception? ☐ Yes ☐ No

11. Has access to contraceptive services been offered to this patient? ☐ Yes ☐ No

****Requests for Total Daily Doses below the threshold in Table 2 may now skip to the Prescriber Signature section. All other requests must complete questions 12–15.*

*Continued on next page. Signature **MUST** be submitted on page 3.*

Magellan HEALTH SERVICES®

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PATIENT NAME: **DATE OF BIRTH:** – –

Narcotic Monitoring Information

12. Has a written medical treatment plan with stated objectives consistent with Board of Medical Examiner's rule 0880-2-.14 (website: http://www.tn.gov/sos/rules) been established? ☐ Yes ☐ No

13. Is the prescriber a TennCare provider with a Medicaid ID? ☐ Yes ☐ No

14. Has a Patient Controlled Substance Agreement been initiated for this patient? ☐ Yes ☐ No

IF YES, will this agreement be re-evaluated every 6 months? ☐ Yes ☐ No

15. Have you performed any of the following activities for this patient?

- ☐ Random urine screen Date: _____
- ☐ Pill counts Date: _____
- ☐ Pharmacy checks Date: _____
- ☐ Re-evaluated for pain relief and improved physical and psychological function Date: _____

16. Has a specialist consultation been performed or scheduled for this patient? ☐ Yes (please specify) ☐ No

- ☐ Neurology ☐ Rheumatology ☐ Oncology
- ☐ Board Certified Pain Management ☐ Other: _____

IF YES, list the name of the specialist? _____

Please note any other information pertinent to this PA request:

_____

_____

_____

Note: Effective 04/01/13, prescriptions that allow more than 7 days of therapy requires the health provider to check the Controlled Substance Monitoring Database (CSMD).

_____ _____

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

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

Fax This Form to: 1-866-434-5523

Mail requests to: TennCare Pharmacy Program
c/o Magellan Health Services
1st floor South, 14100 Magellan Plaza
Maryland Heights, MO 63043
Phone: 1-866-434-5524

Magellan Health Services will provide a response within 24 hours upon receipt.