Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Pharmacy Benefits Prior Authorization Help Desk
Concomitant Benzodiazepine Opioid Prior Authorization (PA)

Instructions: Completion of this prior approval 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**

Virginia Medicaid requires Prior Authorization when a Benzodiazepine is prescribed while patient is taking an Opioid medication to ensure patient safety according to CDC Guideline and FDA Black Box Warning when opioid-benzodiazepine are concurrently used.

FDA Black Box Warning: Concomitant use of opioids with benzodiazepines or other central nervous system (CNS) depressants, including alcohol, may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing for use in patients for whom alternative treatment options are inadequate; limit dosages and durations to the minimum required; and follow patients for signs and symptoms of respiratory depression and sedation.

Intervention: Reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate. Limit dosages and durations to the minimum required. Follow patients closely for signs of respiratory depression and sedation.

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 □ Psychiatrist □ Substance Use Disorder □ Other: ____________________

3- Therapy Prescribed

Drug Name/Form: ________________________________Strength:_________________ Qty Requested: ______________
Directions: _______________________________________ Length of Therapy: _______________________

4-Medical Information

1. Is the request for initial or continuing therapy?
   □ Initial □ Continuing: please provide the start date ____________________

2. Please indicate the patient's diagnosis for taking a benzodiazepine below:
   □ Acute alcohol withdrawal
   □ Adjunct for relief of skeletal muscle spasms
   □ Anxiety
   □ Convulsive disorders

3. Please indicate the patient's diagnosis for taking an opioid below:
   □ Ac ve Cancer Pain
   □ Hospice care/Pallia ve care
   □ aChronic, non-cancer pain
   □ Acute Pain

5-Prescription Monitoring Program (PMP)

4. 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**
5. Document the **fill date of the patient's last opioid Rx:** ___________________________
6. Document the **fill date for the patient's last benzo Rx:** __________________________
7. Does the prescriber attest that he/she will be managing the patient's therapy long term, and that they have read the FDA black box warning on prescribing of Opioids and Benzodiazepines and the dangers involved, and that therapy is medically necessary for this patient?
   □ **Yes** □ **No**
8. If **no** to any of the above, please explain and provide clinical rationale: _____________________________________

____

6- Provider Sign off

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

Physician Signature____	**Date:**

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this tele copied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility