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

Instructions: Completion of this prior authorization (PA) 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 MD Medicaid Formulary can be found at:** http://www.providers.kaiserpermanente.org/mas/formulary.html

CDC Guidelines for Opioid prescribing for Chronic Pain: OPIOIDS ARE NOT RECOMMENDED AS FIRST-LINE TREATMENT FOR CHRONIC PAIN. Please see http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm for additional information.

Prior Authorization is required for:

1) All Long-acting Opioids
2) Any opioid (short- and long-acting) exceeding Morphine Milligram Equivalents (MME) dose of 90 mg/day
3) Opioids Exceeding quantity limits

***Length of PA approval: 30 days for acute conditions, 180 days (6 months) for all excluded conditions and chronic pain

1-Patient Information

Patient Name:____ Kaiser Medical ID#: _________________________________

Date of Birth: _______________ Gender: □ Male □ Female Phone #: ____

Please indicate patient setting: □ Patient is currently an inpatient at a hospital and is being discharged □ Patient is being discharged from Emergency Department □ Outpatient setting providing on going care

Pregnancy status when applicable: □ Yes □ No

2-Provider Information

Provider Name:__________________________ Provider NPI: _____________________

Provider Address:____ Phone ____________________Fax_______________________

Specialty: □ Oncologist □ Hematology □ Chronic Pain Specialist □ Palliative Care □ Other: ___________________

Please check the box that applies:

□ Non-Urgent Review

□ Urgent Review: By checking this box, I certify that applying non-urgent review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature____

3-Important Exclusion Criteria

Important: The remainder of this prior authorization form **does not need to be completed** for patients receiving opioid therapy due to the following conditions, care plans or residential setting:

Active Cancer Treatment: I attest this patient has active cancer. □ Yes □ No
Sickle Cell Disease: I attest this patient has sickle cell disease. □ Yes □ No
Hospice or Palliative Care: I attest this patient is receiving hospice or palliative care. □ Yes □ No
Long Term Care: I attest this patient is in long term care □ Yes □ No

I certify that the benefits of opioid treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Provider Signature____ Date _____________

(If Yes, please sign and submit, no further information required)

***If the above conditions do not apply, please continue to section 4-8.**

4-Alternative Therapy to Schedule II Opioid

Alternative therapy to Schedule II opioid drugs. Complete list of KPMAS MD Medicaid formulary can be found at:
https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_md_health_choice_formulary.pdf

Preferred Alternative Products: **NSAIDs topical and oral; SNRI; Tricyclic Antidepressants; Gabapentin CAPS; Baclofen, Capsaicin topical cream 0.025%**

Has patient tried and failed any of the above non-opioid therapy? □ Yes □ No
If yes, document therapy tried______________________________
If no, document clinical reason______________________________
Has patient tried and failed a formulary opioid therapy? □ Yes □ No If yes, document therapy tried:__________________
If no, provide medically necessary explanation ______________________________

5- Prescription Drug Monitoring Program (PDMP)

Attestation: Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP) on the date of this request to determine whether the patient is receiving dangerous opioid dosages or combinations (such as opioids/benzodiazepines) that put him or her at high risk for fatal overdose. □ **Yes** □ **No**
PDMP FAQ and Registration Website: http://crisphealth.org/services/prescription-drug-monitoring-program-pdmp/pdmp-registration/
CRISP Log-in: https://portal.crisphealth.org/MirthSignOn-idp/sso
Document the **fill date** of the patient's **last opioid** Rx (if applicable): ________________ N/A □

6- Therapy Prescribed

Please indicate the patient's diagnosis for taking an opioid:

□ Post-operative pain □ Acute pain (pain lasting <90 days) □ Chronic pain (pain lasting > 90 days)

Drug Name/Form: ____________________Strength:______________ Qty Requested:__________
Directions:______________________ Length of Therapy:______________ Total Daily Dose_________
Total Daily MME:______ If > 90 MME provide clinical rationale______________________________

Drug Name/Form: ____________________Strength:______________ Qty Requested:__________
Directions:______________________ Length of Therapy:______________ Total Daily Dose_________
Total Daily MME:______ If > 90 MME provide clinical rationale______________________________

Does the patient's total MME exceed 90 mg when including this prescription? □ **Yes** □ **No.** If yes, please provide clinical rationale______________________________

7- Attestations Required for all Prescribers (Choose the one that applies)

For Inpatient Hospital Based, Ambulatory Surgery and Emergency Room Prescribers-Attestation required for each of the following:

- The risks associated with opioid use discussed with patient/patient's household □ Yes □ No
  Naloxone prescription provided or offered to patient/patient's household □ Yes □ No □ N/A
  **N/A applicable when patient is not at high risk and/or is on short-term opioid use
- The patient is exempt from need for patient-provider agreement and random UDS because they are being discharged from hospital/Ambulatory Surgery Center/Emergency Department and opioid treatment is for less than 30 days □ Yes □ No

For Outpatient Prescribers providing ongoing care-Attestation required for each of the following:

- Patient-Prescriber Pain Management/Opioid Treatment Agreement/Contract signed and in medical record □ Yes □ No

Sample Physician/Patient Agreement: https://www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForms.pdf

- Patient has/will have random Urine Drug Screens □ Yes □ No
- Naloxone prescription was provided or offered to patient/patient's household □ Yes □ No □ N/A
  **N/A applicable when patient is not at high risk and/or is on short-term opioid use

8- 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