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

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Short-acting, Long-acting Opioids and Methadone.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103.
KP-MAS Formulary can be found at Pharmacy | Community Provider Portal | Kaiser Permanente

Service Authorization is required for:

1. All Long-Acting Opioids
2. Any Short-Acting Opioid prescribed for >7 days or two 7-day supplies in a 60-day period. The Virginia BOM Regulations limit the treatment of acute pain with opioids to 7 days.
3. Any cumulative opioid prescription exceeding 90 morphine milligram equivalents (MME) per day. Quantity limits apply to each drug.

LENGTH OF AUTHORIZATIONS

• Up to 3 months for (includes HIV/AIDS, Chronic back pain, Arthritis, Fibromyalgia, Diabetic neuropathy, Postherpetic Neuralgia).
• Up to 6 months for chronic pain (includes Cancer pain, Sickle cell disease, Palliative care, End-of-Life Care, Hospice).

Long-Acting Opioids (LAOs): LAOs are indicated for members with chronic, moderate to severe pain who require daily, around-the-clock opioid treatment and require a SA. Consider non-pharmacologic and non-opioid pain treatments prior to treatment with opioids. Members should be considered for buprenorphine analgesic treatment with either topical patch since this product has a ceiling effect with less risk of respiratory depression than other opioids.
https://www.virginiamedicaidpharmacyservices.com/provider/external/medicaid/vamps/doc/enu

1 – Patient Information

Patient Name: ______________________________ Kaiser Medical ID#: _________________ Date of Birth: _____________

2 – Prescriber Information

Prescriber Name: ______________________________ Specialty: ____________________________ NPI: _________________

Prescriber Address: ____

Prescriber Phone #: __________________________Prescriber Fax #: ___________________________

3 – Pharmacy Information

Pharmacy Name: ________________________________ Pharmacy NPI: ____

Pharmacy Phone #_______________________________ Pharmacy Fax #: ____

4 – Drug Therapy Requested

Drug Name/Form: ____
Strength:____
Quantity per Day:____

Short and Long-Acting Opioids (For METHADONE - PLEASE GO TO PAGE 4)

Preferred Long-Acting Opioids (Sch III-VI)	Preferred Long-Acting Opioids (Sch II)	Preferred Short-Acting Opioids
• Butrans® Transdermal Patch	• fentanyl 12, 25, 50, 75, and 100 mcg patches • morphine sulfate ER tab	• codeine/APAP • hydrocodone/APAP • hydrocodone/ibuprofen • hydromorphone • morphine IR • oxycodone IR • oxycodone/APAP • tramadol HCl 50 mg • tramadol HCl/APAP

5– Diagnosis/Clinical Criteria

1. **Length of authorization: 3 months based on the following diagnosis (please check all that apply):**

   ☐ HIV/AIDS ☐ Chronic back pain ☐ Arthritis

   ☐ Fibromyalgia ☐ Diabetic neuropathy ☐ Postherpetic neuralgia

   ☐ Other:____

2. **Length of authorization: 6 months based on the following diagnosis (please check all that apply):**

   ☐ Cancer pain ☐ Sickle cell disease ☐ Palliative care

   ☐ End-of-Life care ☐ Hospice patient

3. Does the prescriber attest that the member has intractable pain associated with active cancer, palliative care (treatment of symptoms associated with life-limiting illnesses), or hospice care? *(IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless a non-preferred is prescribed. If a non-preferred is prescribed also complete question #5)*

   □ No □ Yes

4. Is the member in remission from cancer and is the prescriber safely weaning the member off opioids with a tapering plan*? (IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless a non-preferred drug is prescribed*. *If a non-preferred is prescribed also complete question #5)*

   □ No □ Yes

5. Is the member in a long-term care facility? *(IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless a non-preferred/non-formulary drug is prescribed. If a non-preferred is prescribed also complete question #5)*

   □ No □ Yes

6. Has the member tried and failed any of the following therapies covered without SA (select all that apply)?

   ☐ Baclofen ☐ Capsaicin gel

   ☐ Duloxetine ☐ Gabapentin

   ☐ Lidocaine 5% patch ☐ NSAIDs (oral)

   ☐ Physical therapy ☐ Tricyclic antidepressant (e.g., nortriptyline)

   ☐ Cognitive behavioral therapy (CBT) ☐ Other: ___________________________________

7. If requesting a non-preferred product (e.g., Avinza®, Kadian®, Embeda®), has the member tried and failed an adequate trial of 2 different preferred products?

   □ No □ Yes

   If Yes, please list the drug name, length of trial, and reason for discontinuation.

   ____

8. What is the member's Active Daily MME from the PMP (https://virginia.pmpaware.net/login)?

   MME: ____

   i. If the member's Active Daily MME is greater than or equal to 90, does the prescriber attest that he or she will be managing the member's opioid therapy long term, has reviewed the Virginia BOM Regulations for opioid Prescribing, has prescribed naloxone, and acknowledges the warnings associated with high dose opioid therapy including fatal overdose, and that therapy is medically necessary for this member?

   □ No □ Yes □ N/A

9. If a benzodiazepine prescription has been filled in the past 30 days, does the prescriber attest that he or she has counseled the member on the FDA black box warning on the dangers of prescribing opioids and benzodiazepines, including fatal overdose, has documented that the therapy is medically necessary, and has recorded a tapering plan to achieve the lowest possible effective doses of both opioids and benzodiazepines per the Board of Medicine Opioid Prescribing Regulations?

   □ No □ Yes □ N/A

10. Has naloxone been prescribed for members with risk factors of overdose? Risk factors for overdose include substance use disorder, doses in excess of 50 MME/day, antihistamines, antipsychotics, benzodiazepines, gabapentin, pregabalin, tricyclic antidepressants, or the "Z" drugs (zopiclone, zolpidem, or zaleplon).

    □ No □ Yes

11. If the member is female and between 18 and 45 years old, has the prescriber discussed the risk of neonatal abstinence syndrome and provided counseling on contraceptive options?

    □ No □ Yes

METHADONE Request: Please complete section below questions 1-13

1. Does prescriber attest that the member has intractable pain associated with active cancer, palliative care (treatment of symptoms associated with life limiting illnesses), or hospice care? (IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED.)
   □ No □ Yes

2. Is this member an infant discharged from the hospital on a methadone taper (under 1 year of age)?
   □ No □ Yes

3. Does the member have a contraindication to all other long-acting opioids? (Send MedWatch form.)
   □ No □ Yes

4. Is the member CURRENTLY taking any of the following? Please indicate which.
   ☐ Single entity immediate release or extend release opioids ☐ Benzodiazepines
   ☐ Barbiturates ☐ Carisoprodol ☐ Meprobamate

5. Does the member have a history of (or ever received treatment for) drug dependency or drug abuse?
   □ No □ Yes

6. The Prescriber has checked the PMP on the date of this request to determine whether the member is receiving opioid dosages or dangerous combinations (such as opioids and benzodiazepines) that put him or her at high risk for fatal overdose. https://www.pmp.dhp.virginia.gov/VAPMPWebCenter/login.aspx
   □ No □ Yes

7. Document the fill date for the member's last opioid Rx: ____

8. Document the fill date for the member's last benzodiazepine Rx: ___________________________________

9. Document the member's total drug Morphine Milligram Equivalents from the PMP site: ______ MME/day

10. For MME:
    ☐ From 51 to 90 MME/day (Prescriber should consider offering a prescription for naloxone and overdose prevention education)
    ☐ > 90 MME/day (Prescriber should consider offering a prescription for naloxone and provide overdose prevention education; plus consider consultation with a pain specialist).

    Naloxone injection 0.4 mg/mL and 1 mg/mL vials and syringes and Narcan® Nasal Spray (4 mg of naloxone hydrochloride/0.1 mL spray) are available without a service/prior authorization. Evzio® requires a service authorization.

11. Have you counseled your member of the risks associated with combined use of benzodiazepines and opioids?
    □ No □ Yes

12. Prescriber attests that a treatment plan with goals that addresses benefits and harm has been established with the member.. Plus, there is a SIGNED agreement with the member.
    □ No □ Yes

13. A presumptive urine drug screen (UDS) MUST be done at least annually. The UDS must check for the prescribed drug plus a minimum of 10 substances including heroin, prescription opioids, cocaine, marijuana, benzodiazepines, amphetamines, and metabolites. **Copy of the most recent UDS is attached.**
    □ No □ Yes
    If No, please explain: ____
    ____

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If the member has not tried the preferred agent(s) please provide a rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

____
____
____

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

Prescriber Signature:	**Date:**

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