AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Long-Acting Opioids

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for all non-preferred long-acting opioids. Payment will be considered under the following conditions:

1. Patient has a diagnosis of chronic pain severe enough to require daily, around-the-clock, long-term opioid treatment.
2. Patient has tried and failed at least two nonpharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavioral therapy [CBT]).
3. Patient has tried and failed at least two nonopioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants).
4. There is documentation of previous trial and therapy failure with one preferred long-acting opioid at a maximally tolerated dose.
5. A signed chronic opioid therapy management plan between the prescriber and patient must be included with the prior authorization.
6. The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website at **pmp.iowa.gov/IAPMPWebCenter** and determine if use of a long-acting opioid is appropriate for this member based on review of PMP and the patient's risk for opioid addiction, abuse, and misuse prior to requesting prior authorization.
7. Patient has been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids.
8. Requests for long-acting opioids will only be considered for FDA-approved dosing intervals. As-needed (PRN) dosing will not be considered.

If criteria for coverage are met, an initial authorization will be given for three months. Additional approvals will be considered if the following criteria are met:

1. Patient has experienced improvement in pain control and level of functioning.
2. Prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at **pmp.iowa.gov/IAPMPWebCenter** and has determined continued use of a long-acting opioid is appropriate for this member.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult **www.iowamedicaidpdl.com/pa_criteria**.

Drug Name: Dosage Instructions:

Strength: Quantity: Days Supply:

Diagnosis:

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Document non-pharmacologic therapies (such as physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavioral therapy [CBT])

Non-pharmacologic treatment trial #1: Trial dates:

Failure reason:

Non-pharmacologic treatment trial #2: Trial dates:

Failure reason:

Document two nonopioid pharmacologic therapies (acetaminophen, NSAIDs, or selected antidepressants and anticonvulsants)

Nonopioid pharmacologic trial #1: Trial dates:

Failure reason:

Nonopioid pharmacologic trial #2: Trial dates:

Failure reason:

Document one preferred long-acting opioid treatment failure (including drug name, strength, exact date ranges, and failure reason)

Preferred long-acting opioid trial (name/dose): Trial dates:

Failure reason:

*Please refer to the methadone dosing guidelines located at **www.iadur.org** under the Report Archive tab.

Prescriber review of patient's controlled substances use on the Iowa PMP website ☐ Yes ☐ No

Date reviewed:

Is long-acting opioid use appropriate for patient based on PMP review and patient's risk for opioid addiction, abuse, and misuse? ☐ Yes ☐ No

Has patient been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids? ☐ Yes ☐ No

Renewals

Has patient experienced improvement in pain control and level of functioning? ☐ Yes ☐ No

If yes, describe improvement:

Updated prescriber review of patient's controlled substances use on the Iowa PMP website (since initial request): ☐ Yes ☐ No

Date reviewed:

Attach signed chronic opioid therapy management plan between the prescriber and patient.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.