AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Short 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 short acting opioids. Payment will be considered under the following conditions:

1. Patient has pain severe enough to require opioid treatment; and
2. Patient has tried and failed at least two non-pharmacologic therapies (physical therapy; weight loss; alternative therapies such as manipulation, massage, and acupuncture; or psychological therapies such as cognitive behavior therapy [CBT]); and
3. Patient has tried and failed at least two non-opioid pharmacologic therapies (acetaminophen or NSAIDs); and
4. Patient has documentation of previous trials and therapy failures with three chemically distinct preferred short acting opioids (based on opioid ingredient only) at therapeutic doses; and
5. The prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring program website and has determined that use of a short-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; and
6. 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.

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; and
2. Prescriber has reviewed the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at https://pmp.iowa.gov/IAPMPWebCenter/ and has determined continued use of a short-acting opioid is appropriate for this member.

The required trials may be overridden when documented evidence is provided that use of these agents and/or non-pharmacologic therapies would be medically contraindicated.

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

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Preferred (*please refer to the PDL for a complete list of preferred alternatives)		Non-preferred	
☐ Acetaminophen/Codeine	☐ Oxycodone/ASA	☐ Butalbital/APAP/caff/codeine	☐ Nucynta
☐ Hydrocodone/APAP	☐ Tramadol	☐ Butalbital/ASA/caff/codeine	☐ Opana
☐ Hydromorphone tab		☐ Combunox	☐ Oxycodone/APAP (7.5/325, 10/325)
☐ Meperidine tab		☐ Hydrocodone/APAP (5/300, 7.5/300, 10/300)	☐ Primlev
☐ Morphine Sulfate tab		☐ Hydrocodone/Ibuprofen	☐ Roxicodone
☐ Oxycodone cap/tab		☐ Hydromorphone inj	☐ Xodol
☐ Oxycodone/APAP (5/325)		☐ Lazanda	☐ Other:_____
		☐ Meperidine syp/inj	

Strength: Dosage instructions: Quantity: Days supply:

Diagnosis:

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

Non-pharmacological treatment trial 1:

Trial dates: Failure reason:

Non-pharmacological treatment trial 2:

Trial dates: Failure reason:

Document 2 nonopioid pharmacologic therapies (acetaminophen or NSAIDs)

Nonopioid pharmacologic trial 1:

Name/dose: Trial dates:

Failure reason:

Nonopioid pharmacologic trial 2:

Name/dose: Trial dates:

Failure reason:

Document trials with three preferred chemically distinct short acting opioids

Preferred trial 1:

Drug name: Strength: Dosage instructions:

Trial start date: Trial end date: Specify failure:

Preferred trial 2:

Drug name: Strength: Dosage instructions:

Trial start date: Trial end date: Specify failure:

Preferred trial 3:

Drug name: Strength: Dosage instructions:

Trial start date: Trial end date: Specify failure:

Reason for use of non-preferred drug requiring prior approval:

Other medical conditions to consider:

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

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

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? ☐ No ☐ Yes

Renewals

Has patient experienced improvement in pain control and level of functioning?
☐ No ☐ Yes (describe):

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

Is continued use of a short-acting opioid appropriate for this member?

☐ No ☐ Yes (describe):

Other medical conditions to consider:

Attach lab results and other documentation as necessary.

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 attest 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.