Amerigroup RealSolutions in healthcare

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Pharmacy Analgesic Opioid Prior Authorization Form

Instructions

1. Complete this form in its entirety. Any incomplete sections will result in a delay in processing.
2. We review requests for prior authorization (PA) based on medical necessity only. If we approve the request, payment is still subject to all general conditions of Amerigroup Community Care including current member eligibility, other insurance and program restrictions. We will notify the provider and the member's pharmacy of our decision.
3. To help us expedite your authorization requests, please fax all the information required on this form to 1-855-363-0728.
4. Allow us at least 24 hours to review this request. If you have questions regarding a PA request, call us at 1-800-454-3730. The pharmacy is authorized to dispense up to a 72-hour supply while awaiting the outcome of this request. Please contact the member's pharmacy.
5. Access our website at https://providers.amerigroup.com/MD to view the *Preferred Drug List*.
6. An ICD/diagnosis code is required for all requests. An HCPCS billing code is required for all medical injectable/oncology requests. If the billing facility is different from the requesting physician, the billing facility information will need to be completed.

Member information

Last name First name MI	Amerigroup ID #	Date of birth	Sex ☐ F ☐ M
Member's place of residence: ☐ Home ☐ Nursing facility ☐ Long-term care facility Administration site: ☐ Home ☐ Office ☐ Outpatient facility	Height	Weight	

Medication information (Please use a separate form for each medication request.)

Drug name and strength requested	SIG (dose, frequency and duration)	Quantity
Diagnosis and/or indication	ICD code	HCPCS billing code

PA type

Approval duration: ☐ New prescription — approved for three (3) months ☐ Continuation therapy (patient has been taking this medication) — approved for six (6) months
Request type: ☐ Quantity limit ☐ High dose (≥90 cumulative MED/day) ☐ Long-acting opioid ☐ Nonpreferred ☐ Methadone for pain ☐ Fentanyl ☐ Other: _____

Approval criteria (Please check all boxes that apply.)

Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.

Y	N	Criteria
Section A. Patient meeting one of the following is not required to meet the PA criteria *unless* the requested agent is nonpreferred. For requests for nonpreferred long-acting agents, please proceed to Section F. For requests for nonpreferred short-acting agents, please proceed to Section G.		
☐	☐	Patient has a diagnosis of cancer-related pain and/or is actively undergoing cancer therapy. If yes, please indicate specific diagnosis: _____
☐	☐	Patient has a diagnosis of terminal illness and is receiving palliative/end-of-life care. If yes, please indicate specific diagnosis: _____
☐	☐	Patient has a diagnosis of sickle cell disease.
☐	☐	Patient is currently receiving care at a long-term care facility.
Section B. All request types for patient not meeting one of the criteria under Section A		
☐	☐	Prescriber has reviewed controlled dangerous substance (CDS) prescriptions in Prescription Drug Monitoring Program (PDMP) (CRISP).
☐	☐	Patient has had/will have random urine drug screens before and during treatment.
☐	☐	Naloxone prescription was provided or offered to patient/patient's household.
☐	☐	Patient-prescriber pain management/opioid treatment agreement/contract signed and in medical record.
☐	☐	Prescriber has certified the benefits of opioid treatment for the patient outweigh the risks of treatment.
Section C. All requests for long-acting agents		
☐	☐	Patient has a diagnosis of pain severe enough to require daily, around-the-clock, long-term opioid treatment. If yes, please indicate specific diagnosis: _____
☐	☐	Patient has had an inadequate response to alternative treatment options such as (but not limited to) non-opioid analgesics and immediate-release opioids.
☐	☐	Alternative treatment options would otherwise be inadequate to provide sufficient management of pain.
☐	☐	Patient has contraindications to non-opioid analgesics (such as NSAID use in a patient with active ulcer condition/gastrointestinal bleeding/renal failure).
☐	☐	Patient is 18 years of age or older.
☐	☐	Prescriber has consulted with the patient regarding risks of opioid therapy.
☐	☐	Clear treatment goals have been defined and outlined as part of overall plan.
☐	☐	Requested medication is being used as an as-needed analgesic.
☐	☐	Patient has one of the following conditions: significant respiratory depression, acute or severe bronchial asthma or hypercarbia, or known or suspected paralytic ileus.
Section D. Additional for requests for initial therapy		
☐	☐	Patient is currently taking a short-acting analgesic (e.g., use of opioid analgesia as an inpatient for post-surgical pain).
☐	☐	Patient is transitioning from one long-acting opioid analgesic to another long-acting opioid analgesic.
Section E. Additional for requests for continuation of therapy		
☐	☐	Long-acting opioid therapy has provided meaningful improvement in pain and/or function compared to baseline.
Section F. Additional for requests for nonpreferred long-acting agents *Preferred* long-acting agents are morphine sulfate ER tablets (generic MS Contin), methadone and fentanyl patch (generic Duragesic).		
☐	☐	Patient has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response or intolerance to two preferred long-acting agents.
☐	☐	Patient has completed titration and is already maintained on a stable dose of the requested drug.
☐	☐	Preferred long-acting opioids are unacceptable due to concomitant clinical situations such as (but not limited to) known hypersensitivity to any ingredient not also in the requested nonpreferred agent.

		Please describe medical necessity for nonpreferred agents: _____ _____
Section G. Additional for requests for nonpreferred short-acting agents *Nonpreferred* short-acting agents are all brand products, tapentadol (generic Nucynta) and oxymorphone (generic Opana).		
☐	☐	Patient has had a trial (medication samples/coupons/discount cards are excluded from consideration as a trial) and inadequate response or intolerance to one preferred short-acting agent.
		Please describe medical necessity for nonpreferred agents: _____ _____

Prescriber information

Last name First name MI		NPI # (required)	DEA/license #
Address where service was rendered		City	State
ZIP code	Telephone number ( )	Fax number ( )	
Office contact name		Contact direct phone number	

Billing facility information

Name		NPI #/tax ID (required)	DEA/license #
Address		City	State
ZIP code	Telephone number ( )	Fax number	Office contact name

Pharmacy information

Name	Pharmacy NPI #	Telephone number ( )	Fax number ( )

Signature

I certify the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission or concealment of material may be subject to civil or criminal liability.

Prescriber signature (or authorized representative) Date