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Washington Opioid Pharmacy Prior Authorization Form

Opioids prescribed for chronic use (defined as greater than 42 calendar days within a 90-day period) cannot be authorized unless the provider submits a signed attestation with this prior authorization request. The required *Chronic Opioid Attestation* form is attached. The attestation form will expire on the date specified. If no date is entered, the attestation form will expire in 12 months.

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 based on medical necessity only. If we approve the request, payment is still subject to all general conditions of Amerigroup Washington, Inc. 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 Medicaid authorization requests, please fax all the information required on this form to 1-844-493-9207. Fax all Medicare Part B authorization requests to 1-866-959-1537.
4. Allow us at least 24 hours to review this request. If you have questions regarding a Medicaid prior authorization 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. If you have questions regarding Medicare Part B prior authorizations, please call us at 1-866-797-9884, option 5.
5. Access our website at https://providers.amerigroup.com/WA > Provider Resources & Documents > Pharmacy to view the *Preferred Drug List*.
6. An ICD-10/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
DOB	Height	Weight	Sex (check one) ◯ F ◯ M
Member's place of residence: ◯ Home ◯ Nursing facility		Administration site: ◯ Home ◯ Office ◯ Outpatient facility	

Medication information

Drug name and strength requested	SIG (dose, frequency and duration)	HCPCS billing code

Diagnosis and/or indication	ICD-10 code

Has the member tried other medications to treat this condition?	Drug(s) name and strength	
◯ **Yes.** Provide this information in the area to the right. You may be asked to provide supporting documentation such as: • Copies of medical records. • Office notes. • Complete *FDA MedWatch Form*. ◯ **No.** Explain why not:	Date range of use	SIG codes for dose and frequency
	Did the member experience any of the below? ◯ Adverse reaction ◯ Inadequate response ◯ Other	
	Briefly describe details of adverse reaction, inadequate response or other in the space provided below:	

Describe medical necessity for nonpreferred medication(s) or for prescribing outside of FDA labeling:

List all current medications including dose and frequency:

Other pertinent information:

Diagnostic studies and/or laboratory tests performed

List all tests done within the past 30 days that are related to the diagnosis of the medication requested.

Labs:			**Diagnostic tests:**		
Test	Date	Result	Procedure	Date	Result

Prescriber information

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

Billing facility information

Name	NPI/tax ID (required)	DEA/license #
Address		
City	State	ZIP code

Phone	Fax	Office contact name

Pharmacy information

Name	Pharmacy NPI
Phone	Fax

Signature

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

Prescriber's signature (or authorized representative)	Date

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Chronic Opioid Attestation

Please provide the information below, attach supporting documentation, sign, date, and return by fax to **1-800-359-5781.**
Without this information, we may deny the request.

For more information go to: https://www.hca.wa.gov/billers-providers/programs-and-services/opioids

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength		Directions for use	

Use of any opioid for more than 42 days within a 90 day period is considered chronic use. Use of opioids for more than 42 days may be authorized in 6 month intervals when the prescriber signs the attestation below. Quantity limits do not apply for existing chronic users or those with a diagnosis or pharmacy claim for active cancer treatment, hospice, palliative care, or end-of-life care.

Criteria for chronic use of opioids for the treatment of non-cancer pain:

- The patient has an on-going clinical need for chronic opioid use at the prescribed dose (more than 42 days per 90 day calendar period) that is documented in the medical record.
- The patient is using appropriate non-opioid medications, and/or non-pharmacologic therapies; OR
- The patient has tried and failed non-opioid medications and non-pharmacologic therapies for the treatment of this pain condition; AND
- For long-acting opioids**,** the patient must be using or had trials of short-acting opioid therapy for at least 42 days; OR
  - The reason for inadequate response to short-acting opioid therapy is documented in the medical record; OR
  - Justification of beginning an opiate naïve patient on a long-acting opioid is documented in the medical record;
- The provider has recorded baseline and ongoing assessments of measurable, objective pain scores and function scores. These should be tracked serially in order to demonstrate clinically meaningful improvements in pain and function; AND
- The patient has been screened for mental health disorders, substance use disorder, naloxone use; AND
- The provider will conduct periodic urine drug screens; AND
- The provider has checked the PDMP for any other opioid use and concurrent use of benzodiazepines and other sedatives; AND
- The provider has discussed with the patient the realistic goals of pain management therapy and has discussed discontinuation as an option during treatment; AND
- The provider confirms that the patient understands and accepts these conditions and the patient has signed a pain contract or informed consent document.

1. I attest that all of the above criteria are met, or there is documentation in patient's chart for why one or more are not applicable ◯ Yes ◯ No

2. The requested treatment is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical record ◯ Yes ◯ No

3. How long should this attestation be effective for? Please specify date:
   (**Note**: The attestation form will expire on the date specified. If no date is entered, the attestation form will expire in 12 months.

By signing below I certify that the information on this form is true and understand that any misrepresentation or any concealment of any information requested may subject me to recoupment upon an audit.

Prescriber signature	Prescriber specialty	Date