Opioid Analgesic Treatment Worksheet

☐ **Aetna Better Health of Louisiana**
Fax: 1-844-699-2889
www.aetnabetterhealth.com/louisiana/providers/pharmacy

☐ **LA Legacy Fee for Service (FFS) Medicaid**
Fax: 1-866-797-2329
www.lamedicaid.com

☐ **Amerigroup**
Fax: 1-888-346-0102
www.myamerigroup.com/la/pages/medicaid.aspx

☐ **LA Healthcare Connections**
Fax: 1-866-399-0929
www.louisianahealthconnect.com/for-members/pharmacy-services/

☐ **AmeriHealth Caritas Louisiana**
Fax: 1-855-452-9131
www.amerihealthcaritasla.com/pharmacy/index.aspx

☐ **UnitedHealthcare**
Fax: 1-866-940-7328
www.uhccommunityplan.com/health-professionals/la/pharmacy.html

Please fax this form to the appropriate plan using the fax number provided above.

Is this request for medication prescribed for treatment of pain related to cancer, palliative care, or end-of-life care?

☐ *Yes* ☐ *No* ***If yes, this form is not required. For FFS recipients, pharmacist must enter diagnosis code at Point of Sale.***

Recipient Name:	Policy ID #:	Recipient DOB:	
EPSDT Support Coordinator (Name/Address): *(optional)*	Medication Allergies:	Recipient Weight (kg):	Recipient Height (ft/in):
Prescriber Name:	Prescriber Specialty:	Medicaid Provider ID # or NPI#:	
Call-Back Phone#:	Office Fax#:	Office Contact:	

This request is for: ☐ **QUANTITY LIMIT OVERRIDE FOR OPIOID ANALGESIC** ☐ **TREATMENT WITH LONG-ACTING OPIOID ANALGESIC**

DRUG INFORMATION (one drug per request)

DRUG NAME/DOSAGE FORM_____STRENGTH_____

REQUESTED MEDICATION IS A ☐ SHORT-ACTING OPIOID ☐ LONG-ACTING OPIOID

DIRECTIONS_____QUANTITY REQUESTED_____

REQUEST IS FOR: ☐ INITIATION OF THERAPY ☐ CONTINUATION OF THERAPY

For continuation of therapy, is the dose currently being tapered? ☐ Yes ☐ No

If no, explain:_____

TREATMENT INFORMATION

This medication is being used for: ☐ acute condition ☐ chronic condition (check one only)

Is this medication being used for moderate to severe neuropathic pain or fibromyalgia? ☐ Yes ☐ No

Is this medication being used for postoperative pain? ☐ Yes ☐ No If yes, date of surgery_____

Diagnoses for which the opioid is prescribed (include primary and secondary diagnoses applicable to this request): (ICD code and description)
Diagnosis_____ Date of Diagnosis_____ Diagnosis_____ Date of Diagnosis_____

List other **treatments** that have been **tried** for this condition, both pharmacological and non-pharmacological:

Pharmacological Treatments

Drug / Strength	Long Acting or Short Acting (if applicable)	Directions	Start Date / End Date	Reason for discontinuation (if applicable)

Non-pharmacological Treatments

Treatment	Start Date/End Date

List other **opioid analgesics** that are to be used **concurrently** with the **requested medication** for treatment of pain:

Drug	Dosage form	Strength	Directions	Start Date

For **quantity limit override**, explain in detail the need for requested quantity: _____

_____

PRESCRIBER ATTESTATION

Please indicate YES/True or NO/False for each of the following attestations. Explanation is required for each 'No/False' answer in order for the request to be considered for approval. For short-acting opioids, complete A – H; for long-acting opioids, complete A – M.

	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
SHORT AND LONG-ACTING OPIOIDS			A. A complete **assessment** for pain and function was performed for this patient and **documentation is attached**.
			B. The patient has been **screened for substance abuse / opioid dependence** and **documentation is attached**.
			C. The **PMP** (Prescription Monitoring Program) will be accessed **each** time a controlled prescription is written for this patient.
			D. A **treatment plan** which includes current and previous goals of therapy for both pain and function has been developed for this patient.
			E. **Criteria** for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.
			F. **Benefits and potential harms** of opioid use have been discussed with this patient. In addition, if the patient has concurrent comorbidities or is taking medications that could potentially cause drug-drug interactions, an assessment of increased risk for respiratory depression has been completed and discussed with the patient. The risk of combining opioids with other central nervous system depressants, such as benzodiazepines, alcohol, or illicit drugs such as heroin, has also been specifically addressed.
			G. An **Opioid Treatment Agreement** signed by both the patient and prescriber is on file.
			H. The patient will be **closely monitored** for the duration of treatment with this medication.
LONG-ACTING OPIOIDS			I. The patient requires continuous **around the clock** analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.
			J. Patient previously utilized at least two weeks of short-acting opioids for this condition. Please enter drug(s), dose, duration and date of trial in *Pharmacological Treatment Section* on page 1.
			K. Medication has **not** been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time.
			L. Medication has **not** been prescribed for use as an as-needed (PRN) analgesic.
			M. Prescribing information for requested product has been **thoroughly reviewed** by prescriber.

*IF NO FOR **ANY** OF THE ABOVE, PLEASE EXPLAIN:*

THIS SECTION APPLIES TO **AETNA BETTER HEALTH OF LOUISIANA** RECIPIENTS ONLY.

Does the Opioid Treatment Agreement include the following? ☐ Yes ☐ No

- Consequences of lost medication or taking more than prescribed
- Consequences of obtaining controlled substances from other prescribers
- Member agreement to only use one pharmacy

Is the request for a **non-preferred agent**? ☐ Yes ☐ No

- If yes, list formulary agents tried:_____

Is the request for Nucynta ER for the treatment of **diabetic peripheral neuropathy**? ☐ Yes ☐ No

- If yes, has the patient had an inadequate response or intolerance to duloxetine AND tramadol AND at least one additional formulary medication (e.g., gabapentin, amitriptyline, nortriptyline, or topical capsaicin)? ☐ Yes ☐ No
- If yes, were the trials of the formulary agents at least 4 weeks and at maximum tolerated doses? ☐ Yes ☐ No

For questions, please call 1-855-242-0802.

THIS SECTION APPLIES TO **AMERIGROUP** RECIPIENTS ONLY.

For long-acting opioids, the following must also be met:

1. If the request is for a non-preferred agent, individual must meet the following criteria:
   a. Individual has had a trial and inadequate response or intolerance to two preferred long-acting agents; **OR**
   b. Individual has completed titration and is already maintained on a stable dose of the requested drug; **OR**
   c. The preferred long-acting opioids are not acceptable due to concomitant clinical situations, such as but not limited to known hypersensitivity to any ingredient which is not also in the requested non-preferred agent; **OR**
   d. Embeda ER, Hysingla ER, MorphaBond, Xtampza ER, or Zohydro ER abuse deterrent may be approved if the individual has need for an abuse deterrent formulation based upon a history of substance abuse disorder OR individual's family member or household resident has active substance abuse disorder or a history of substance abuse disorder; **OR**
   e. Butrans (buprenorphine transdermal patch) or Belbuca (buprenorphine buccal film) may be approved if there is concern for abuse or dependence with pure opioid agents.

For questions, please call 1-800-454-3730.

THIS SECTION APPLIES TO **AMERIHEALTH CARITAS** LOUISIANA RECIPIENTS ONLY.

Please note:

For short-acting opioids, if these criteria are met, the request will be approved with up to 3 months duration. For long-acting opioids, if these criteria are met, the request will be approved with up to 6 months duration. Also, if this request for is for a medication prescribed for treatment of pain related to cancer, palliative care, or end-of-life care, no further review is necessary as it will pay at POS with appropriate diagnosis code.

1. If this request is for a non-formulary opioid drug, patient must also try and fail up to 3 formulary alternatives before approving non-formulary opioids.
   - If yes, list formulary agents tried:_____

2. For requests to exceed the quantity limits for **short-acting opioids**:
   a. Has the patient tried and failed (or is the patient currently using) 2 or more of the following:

Non-Opioid Formulary Treatment Alternatives for Fibromyalgia or Peripheral Neuropathy

Antidepressants: Amitriptyline, Nortriptyline, Duloxetine, Venlafaxine, Savella
Anticonvulsants: Gabapentin capsules, Carbamazepine
Muscle Relaxants: Baclofen, Cyclobenzaprine, Methocarbamol, Tizanidine tablets
NSAIDs: Aspirin, Celebrex (PA required), Diclofenac, Etodolac, Ibuprofen, Indomethacin, Meloxicam, Nabumetone (PA required), Naproxen, Salsalate, Sulindac
Non-Opioid Analgesics: Acetaminophen

- o If yes, list alternatives tried:_____

Non-Opioid Formulary Treatment Alternatives for Back Pain or Other Generalized Pain

Muscle Relaxants: Baclofen, Cyclobenzaprine, Methocarbamol, Tizanidine tablets
NSAIDs: Aspirin, Celebrex (PA required), Diclofenac, Etodolac, Ibuprofen, Indomethacin, Meloxicam, Nabumetone (PA required), Naproxen, Salsalate, Sulindac
Non-Opioid Analgesics: Acetaminophen

- o If yes, list alternatives tried:_____

   b. Explain medical necessity: _____

_____

3. For requests for **Vicoprofen**:
   a. Diagnosis of acute pain? ☐ Yes ☐ No
   b. Documented trial and failure or intolerance to at least three of the following medications: oxycodone/acetaminophen, hydrocodone/acetaminophen, acetaminophen/codeine, morphine and hydromorphone? ☐ Yes ☐ No

4. For requests for **long-acting opioids** and/or to exceed the quantity limits for **long-acting opioids**:
   a. Explain medical necessity:_____

   _____

5. For requests for **Oxycontin Extended Release**:
   a. Documented trial and failure or intolerance to sustained-release morphine sulfate? ☐ Yes ☐ No
   b. Documented trial and failure or intolerance to fentanyl patches? ☐ Yes ☐ No

6. Physician address:
   (Street)_____

   (City)_____(State)_____(Zip)_____

For questions, please call 1-800-684-5502.

THIS SECTION APPLIES TO **LA LEGACY FFS MEDICAID** RECIPIENTS ONLY.

If the request is for a non-preferred agent, is there a clinical reason why a preferred agent cannot be used? ☐ Yes ☐ No
If yes, explain:_____
Is the patient currently a resident in a long-term care facility? ☐ Yes ☐ No
If yes, provide facility name, phone number, and contact person:_____
_____

For questions, please call 1-866-730-4357.

THIS SECTION APPLIES TO **LA HEALTHCARE CONNECTIONS** RECIPIENTS ONLY.

1. If this is a non-formulary request, member must try and fail 2 formulary alternatives before non-formulary request can be considered for approval.
2. Short Term Therapy (up to a total 90 days therapy within 180 days): Member may only have 2 concurrent opioids and total opioid dose may not exceed 90mg morphine equivalent (MME) dosing per day. **State Mandated quantity/days' supply limits apply.**
3. Long Term Therapy (excess of 90 days therapy within 180 days): A. Member must have failed at least 2 non-opioid ancillary treatments (NSAIDS, APAP, anticonvulsants, antidepressants, etc.) B. Immediate release must be failed before extended release can be approved. C. Member may only have 2 concurrent opioids with therapy consisting of one short acting and one long acting opioid. D) Total opioid dose may not exceed 90mg morphine equivalent (MME) dosing per day.
   If criteria are met, chronic pain approval duration=3 months and Sickle cell crisis, cancer pain, palliative care approval duration=12months.
   **State Mandated quantity/days' supply limits apply. **
4. Request for > 2 opioid analgesics concurrently- Cancer pain/Palliative care/Sickle cell crisis - **A.** Opioid therapy must be prescribed by a specialist for sickle cell crisis pain/cancer pain/palliative care; **B.** Prescriber will be requested to discontinue opioid analgesic to meet the two (2) or less opioid limit by the following methods: 1. Addition of an extended release opioid analgesic, if not present; 2. Upward titration of existing opioids within plan allowed quantity limits; **C.** Prescriber must provide documented clinical rationale for the use of > 2 opioid analgesics concurrently instead of adding an extended release opioid or titrating/discontinuing current opioid analgesics.
   ** If criteria are met, approval duration=6 months.**
   State Mandated quantity/days' supply limits apply.

For questions, please call 1-888-929-3790.

THIS SECTION APPLIES TO **UNITED HEALTHCARE** NON-CANCER PAIN RECIPIENTS ONLY.

Please provide defined **treatment goals**, including estimated duration of treatment:

- Treatment goals: _____
- Estimated duration of treatment: _____

Does the treatment plan include use of a **non-opioid analgesic and/or non-pharmacologic intervention**? ☐ Yes ☐ No

- List other treatment interventions: _____
  _____

Does the dose of the long-acting opioid **exceed the maximum MED** ? ☐ Yes ☐ No

- If "Yes", did you consult a pain specialist, defined as a prescriber with a pain management specialty designated by the American Board of Anesthesiology, or one of the following specialties: hematology, oncology, anesthesiology, neurology, or psychiatry ? ☐ Yes ☐ No
- Document prescriber specialty and total daily dose: _____

If the request is for a **non-preferred agent**, is there a clinical reason why a preferred agent cannot be used? ☐ Yes ☐ No

- If yes, explain:_____

Complete the two questions below only if the medication is being prescribed for **moderate to severe neuropathic pain or fibromyalgia**:

- Has the patient exhibited an adequate response to eight weeks of treatment with gabapentin titrated to a therapeutic dose?
  ☐ Yes ☐ No If "Yes", document duration and date of trial: _____

- Has the patient not exhibited an adequate response to at least six weeks of treatment with a tricyclic antidepressant titrated to a therapeutic dose?
  ☐ Yes ☐ No If "Yes", document duration and date of trial: _____

Complete the two questions below only if the medication is being prescribed for **post-operative pain**:

- Is the patient already receiving chronic opioid therapy prior to surgery? ☐ Yes ☐ No
- Is the post-operative pain expected to be moderate to severe and persist for an extended period of time? ☐ Yes ☐ No

Complete the question below only if the medication request is a **reauthorization**:

Has the patient demonstrated meaningful improvement in pain and function using a validated instrument (e.g. Brief Pain Inventory)?
☐ Yes ☐ No

- Score: _____
- Instrument used: _____

Rationale for not tapering and discontinuing long-acting opioid:
_____
_____
_____

For questions, please call 1-800-310-6826.

Opioid overdose reversal medications are a covered benefit. Prior authorization is not required. CDC guidelines recommend offering naloxone to patients at increased risk of overdose, defined as: history of overdose or substance use disorder, doses ≥ 50 MED /day, or concurrent use with benzodiazepines. Please refer to our Preferred Drug List for preferred products.

I certify that the benefits of opioid treatment for this patient outweigh the risks of treatment and that the information provided herein is true and accurate to the best of my knowledge and may be subject to a routine audit requesting the medical information necessary to verify the accuracy of the information provided.

Prescriber's Signature _____Date _____