SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Methadone

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

- ***Please verify that the daily dose limits is not exceeded. The list can be found at the web URL:** https://www.virginiamedicaidpharmacyservices.com/provider/external/medicaid/vamps/doc/en-us/VAMPS_Short_and_Long_Acting_Opioid_Daily_Dose_Limit.pdf

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

TREATMENT INFORMATION: Check applicable boxes below to qualify or authorization may be delayed

Prescriber's Specialty (check applicable box below):

❑ **Oncology**	❑ **Sickle Cell**	❑ **Pain Specialist**	❑ **Palliative Care**	❑ **Other:** _____

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DIAGNOSIS: **Check box below that applies. Diagnosis must be checked for approval.**	
❑ Metastatic Neoplasia	❑ Chronic Severe Pain
❑ Sickle Cell	❑ Other: _____

1. Does prescriber attest that the member has intractable pain associated with cancer, sickle cell disease, palliative care (treatment of symptoms associated with life limiting illnesses), or hospice care? **(IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED.)**

   ❑ Yes ❑ No

HISTORY: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

2. Is this member an infant discharged from the hospital on a methadone taper (under 1 year of age)?

   ❑ Yes ❑ No

3. Has the member tried and failed at least 2 or more preferred long-acting opioids*? If Yes, check below:

   ❑ Yes ❑ No

   ❑ Fentanyl 12, 25, 50, 75& 100mcg patches (generic Duragesic)
   ❑ morphine sulfate ER tablets

   - ***Requires Prior Authorization. Form can be found at the web URL:** https://www.sentarahealthplans.com/en/providers/authorizations/prescription-drugs/medicaid-drug-authorization-forms under the heading "Opioids (All Preferred and Non-Preferred) (Long-Acting and Short-Acting Opioids)"

4. Does the member have a contraindication to all other long-acting opioids? (**Send MedWatch form**)

   ❑ Yes ❑ No

5. Is the member **CURRENTLY** taking any of the following? (Please indicate which)

❑ benzodiazepines	❑ barbiturates	❑ carisoprodol
❑ meprobamate	❑ single entity immediate release or extend release opioids	

6. Does the member have a history of (or ever received treatment for) drug dependency or drug abuse?

   ❑ Yes ❑ No

PRESCRIPTION MONITORING PROGRAM (PMP)
https://virginia.pmpaware.net/login

7. Prescriber has checked the PMP on the date of this request to determine whether member is receiving opioid dosages or dangerous combinations (such as opioids and benzodiazepines) that put him or her at high risk for fatal overdose.

   ❑ Yes ❑ No

8. Document the fill date for the member's last **opioid** Rx: _____
9. Document the fill date for the member's last **benzodiazepine** Rx: _____

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10. Document the member's total drug Morphine Milligram Equivalents from the PMP site: _____ MME/day
11. For MME:
    - ❑ From 51 to 90 MME/day (Prescriber should consider offering a prescription for naloxone and overdose prevention education)
    - ❑ >90 MME/day (Prescriber should consider offering a prescription for naloxone and provide overdose prevention education; plus consider consultation with a pain specialist).

    Naloxone products are available without a prior authorization.

TREATMENT PLAN

FDA BLACK BOX WARNING: **Health care professionals** should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to members for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect. Warn members and caregivers about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms. Avoid prescribing prescription opioid cough medicines for members taking benzodiazepines or other CNS depressants, including alcohol. For more information, visit https://www.fda.gov/drugs/drug-safety-communications/fda-requiring-opioid-pain-medicine-manufacturers-update-prescribing-information-regarding-long-term.

12. Have you counseled your member of the risks associated with combined use of benzodiazepines or other CNS depressants and opioids? ❑ Yes ❑ No

    Tapering Guidelines for Opioids and Benzodiazepines: https://www.oregon.gov/omb/Topics-of-Interest/Documents/Oregon-Opioid-Tapering-Guidelines.pdf
13. Prescriber attests that a treatment plan with goals that addresses benefits and harm has been established with the member and the following bullets are included. Plus, there is a SIGNED agreement with the member.
    - Established expected outcome and improvement in both pain relief and function or just pain relief, as well as limitations (i.e., function may improve yet pain persists OR pain may never be totally eliminated)
    - Established goals for monitoring progress toward member-centered functional goals: e.g., walking the dog or walking around the block, returning to part-time work, attending family sports, or recreational activities, etc.
    - Goals for pain and function, how opioid therapy will be evaluated for effectiveness and the potential need to discontinue if not effective
    - Emphasize serious adverse effects of opioids (including fatal respiratory depression and opioid use disorder, OR alter the ability to safely operate a vehicle)
    - Emphasize common side effects of opioids (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, withdrawal)

    ❑ Yes ❑ No

    Sample Physician/Patient Agreement:
    https://www.fda.gov/files/drugs/published/Opioid-Patient-Prescriber-Agreement-(PPA).pdf

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14. A presumptive urine drug screen (UDS) MUST be done at least annually. The UDS must check for the prescribed drug plus a minimum of 10 substances including heroin, prescription opioids, cocaine, marijuana, benzodiazepines, amphetamines, and metabolites. **Copy of the most recent UDS is attached.**

    ❑ Yes ❑ No If NO, please explain:

    _____

    _____

    _____

Note:

Length of authorizations:

- Up to 3 months for (includes HIV/AIDS, Chronic back pain, Arthritis, Fibromyalgia, Diabetic neuropathy, Post herpetic Neuralgia)
- Up to 6 months for chronic pain (includes Cancer pain, Sickle cell disease, Palliative care, End-of-Life Care, Hospice)
- Sentara does not cover any form of methadone for the treatment of opioid addiction through pharmacy POS

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

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