

# 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: Opioids (SHORT AND LONG-ACTING)

This request is for (check **ALL** that apply):

|                                              |                                             |                               |
|----------------------------------------------|---------------------------------------------|-------------------------------|
| <input type="checkbox"/> Short-Acting Opioid | <input type="checkbox"/> Long-Acting Opioid | <input type="checkbox"/> Both |
|----------------------------------------------|---------------------------------------------|-------------------------------|

### Prior Authorization is required for:

1. All Long Acting Opioids
2. Any Short-Acting Opioid prescribed for > 7 days or two (2) 7-day supplies in a in a 60 day period. The Virginia BOM Regulations limit the treatment of acute pain with opioids to 7 days and post- op pain to no more than 7 days.
3. Any cumulative opioid prescription exceeding 90 morphine milligram equivalents (MME) per day. Quantity limits apply to each drug.
  - [https://www.virginiamedicaidpharmacyservices.com/provider/external/medicaid/vamps/doc/en-us/VAMPS\\_Short\\_and\\_Long\\_Acting\\_Opioid\\_Daily\\_Dose\\_Limit.pdf](https://www.virginiamedicaidpharmacyservices.com/provider/external/medicaid/vamps/doc/en-us/VAMPS_Short_and_Long_Acting_Opioid_Daily_Dose_Limit.pdf)

**Long-Acting Opioids (LAOs):** LAOs are indicated for patients with chronic, moderate to severe pain who require daily, around-the-clock, chronic opioid treatment and require a PA. Consider non-pharmacologic and non-opioid pain treatments prior to treatment with opioids. Members should be considered for buprenorphine analgesic treatment with buprenorphine topical patch since these products have a ceiling effect with less risk of respiratory depression than other opioids.

**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: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_

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**DRUG INFORMATION:** Authorization may be delayed if incomplete.

Drug Name/Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Weight: \_\_\_\_\_ Date: \_\_\_\_\_

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

Drug Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Weight: \_\_\_\_\_ Date: \_\_\_\_\_

**Alternative Therapy to Schedule II Opioids:** Based on the Virginia Board of Medicine's Opioid Prescribing Regulations, Opioids are **NOT** recommended as first line treatment for acute or chronic pain. For additional information please see VA Board of Medicine Regulations at:

[https://www.dhp.virginia.gov/medicine/medicine\\_laws\\_regs.htm](https://www.dhp.virginia.gov/medicine/medicine_laws_regs.htm)

**Preferred Pain Relievers available without PA include:** NSAIDS topical and oral, SNRIs, tricyclic antidepressants, gabapentin, baclofen, Capsaicin topical cream 0.025%, Lidocaine 5% Patch and pregabalin (Lyrica®). Consider alternative therapies to Schedule II opioid drugs due to their high potential for abuse and misuse. A complete list of Health Plan's covered drugs can be found at:

<https://www.sentarahealthplans.com/providers/pharmacy/Formularies-and-drug-lists>

**Clinical Criteria/Treatment Information:** 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. **(PA Criteria Aligns with Virginia Board of Medicine's Regulations Governing Prescribing of Opioids and Buprenorphine.)**

**Length of Authorization - 3 months based on the following Diagnosis (please check all that apply):**

- |                                       |                                              |                                                 |
|---------------------------------------|----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> HIV/AIDS     | <input type="checkbox"/> Chronic back pain   | <input type="checkbox"/> Arthritis              |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Diabetic neuropathy | <input type="checkbox"/> Postherpetic Neuralgia |
| <input type="checkbox"/> Other: _____ |                                              |                                                 |

**Length of Authorization - 6 months based on the following Diagnosis (please check all that apply):**

- |                                           |                                              |                                          |
|-------------------------------------------|----------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Cancer Pain      | <input type="checkbox"/> Sickle Cell disease | <input type="checkbox"/> Palliative Care |
| <input type="checkbox"/> End-of-Life Care | <input type="checkbox"/> Hospice patient     |                                          |

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|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                  |                                                                         |                                        |                                        |                                     |                                             |                                     |                                                             |                                           |                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------|----------------------------------------|-------------------------------------|---------------------------------------------|-------------------------------------|-------------------------------------------------------------|-------------------------------------------|---------------------------------------|--|
| <p>1. Does prescriber attest that the member has intractable pain associated with active cancer, palliative care (<b>treatment of symptoms associated with life-limiting illnesses</b>), or hospice care? (IF <b>YES</b>, please sign and submit, no further information required <b>UNLESS</b> a non-preferred/non-formulary drug is prescribed. See <b>Q6</b> if non-formulary drug is prescribed.)</p>                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> YES<br><input type="checkbox"/> NO                                                      |                                                                         |                                        |                                        |                                     |                                             |                                     |                                                             |                                           |                                       |  |
| <p>2. Is member in remission from cancer and prescriber is safely weaning patient off opioids with a tapering plan? (IF <b>YES</b>, please sign and submit, no further information required <b>UNLESS</b> a non-preferred/non-formulary drug is prescribed. See <b>Q6</b> if non-formulary drug is prescribed.)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> YES<br><input type="checkbox"/> NO                                                      |                                                                         |                                        |                                        |                                     |                                             |                                     |                                                             |                                           |                                       |  |
| <p>3. Is member in a long-term care facility? (IF <b>YES</b>, please sign and submit, no further information required <b>UNLESS</b> a non-formulary drug is prescribed. See <b>Q6</b> if non-formulary drug is prescribed.)</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> YES<br><input type="checkbox"/> NO                                                      |                                                                         |                                        |                                        |                                     |                                             |                                     |                                                             |                                           |                                       |  |
| <p>4. Is this medication used to treat?</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> Acute Pain (less than 90 days)<br/> <input type="checkbox"/> Chronic Pain (90 days or greater)         </div> <div style="width: 45%;"> <input type="checkbox"/> Post-operative Pain         </div> </div>                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> YES<br><input type="checkbox"/> NO                                                      |                                                                         |                                        |                                        |                                     |                                             |                                     |                                                             |                                           |                                       |  |
| <p>5. Please indicate if member has tried and failed any of the following therapies covered <b>without</b> PA (select <b>ALL</b> that apply):</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> baclofen</td> <td><input type="checkbox"/> tricyclic antidepressant (e.g., nortriptyline)</td> </tr> <tr> <td><input type="checkbox"/> NSAIDs (oral)</td> <td><input type="checkbox"/> Capsaicin Gel</td> </tr> <tr> <td><input type="checkbox"/> gabapentin</td> <td><input type="checkbox"/> Lidocaine 5% Patch</td> </tr> <tr> <td><input type="checkbox"/> duloxetine</td> <td><input type="checkbox"/> Cognitive behavioral therapy (CBT)</td> </tr> <tr> <td><input type="checkbox"/> Physical Therapy</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table> | <input type="checkbox"/> baclofen                                                                                | <input type="checkbox"/> tricyclic antidepressant (e.g., nortriptyline) | <input type="checkbox"/> NSAIDs (oral) | <input type="checkbox"/> Capsaicin Gel | <input type="checkbox"/> gabapentin | <input type="checkbox"/> Lidocaine 5% Patch | <input type="checkbox"/> duloxetine | <input type="checkbox"/> Cognitive behavioral therapy (CBT) | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Other: _____ |  |
| <input type="checkbox"/> baclofen                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> tricyclic antidepressant (e.g., nortriptyline)                                          |                                                                         |                                        |                                        |                                     |                                             |                                     |                                                             |                                           |                                       |  |
| <input type="checkbox"/> NSAIDs (oral)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> Capsaicin Gel                                                                           |                                                                         |                                        |                                        |                                     |                                             |                                     |                                                             |                                           |                                       |  |
| <input type="checkbox"/> gabapentin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> Lidocaine 5% Patch                                                                      |                                                                         |                                        |                                        |                                     |                                             |                                     |                                                             |                                           |                                       |  |
| <input type="checkbox"/> duloxetine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> Cognitive behavioral therapy (CBT)                                                      |                                                                         |                                        |                                        |                                     |                                             |                                     |                                                             |                                           |                                       |  |
| <input type="checkbox"/> Physical Therapy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Other: _____                                                                            |                                                                         |                                        |                                        |                                     |                                             |                                     |                                                             |                                           |                                       |  |
| <p>6. If requesting a <b>non-preferred</b> drug (i.e., Avinza<sup>®</sup>, Kadian<sup>®</sup>, Embeda<sup>®</sup>), has member tried and failed an adequate trial of <b>two (2)</b> different <b>Preferred</b> drugs?</p> <p>If <b>YES</b>, please list drug name, length of trial, and reason for discontinuation:</p> <p>_____</p> <p>_____</p> <p>_____</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> N/A product is preferred<br><input type="checkbox"/> YES<br><input type="checkbox"/> NO |                                                                         |                                        |                                        |                                     |                                             |                                     |                                                             |                                           |                                       |  |

|                                             |                                                                                                                                                                        |
|---------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Preferred Long- Acting Opioids (Sch III-IV) | buprenorphine (generic Butrans <sup>®</sup> )<br>Butrans <sup>®</sup> Transdermal Patch                                                                                |
| Preferred Long- Acting Opioids (Sch II)     | Fentanyl 12, 25, 50, 70 & 100 mcg patches<br>morphine sulfate ER tab                                                                                                   |
| Preferred Short-Acting Opioids              | codeine/APAP<br>hydrocodone/APAP<br>hydrocodone/ibuprofen<br>hydromorphone<br>morphine IR<br>oxycodone IR<br>oxycodone/APAP<br>tramadol HCL 50 mg<br>tramadol HCL/APAP |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|
| <p>7. Provide member's Active Daily MME from the PMP (<a href="https://virginia.pmpaware.net">https://virginia.pmpaware.net</a>)</p> <p><b>MME:</b> _____</p> <ul style="list-style-type: none"> <li>If member's Active Daily MME is greater than or equal to 90, does the prescriber attest that he/she will be managing the member's opioid therapy long term, has reviewed the Virginia BOM Regulations for Opioid Prescribing, has prescribed naloxone, and acknowledges the warnings associated with high dose opioid therapy including fatal overdose, and that therapy is medically necessary for this member?</li> </ul> | <input type="checkbox"/> YES<br><input type="checkbox"/> NO<br><input type="checkbox"/> N/A, MME is less than 90       |
| <p>8. If benzodiazepine filled in past 30 days, does prescriber attest that he/she has counseled the member on the FDA black box warning on the dangers of prescribing opioids and benzodiazepines including fatal overdose, has documented that the therapy is medically necessary, and has recorded a tapering plan to achieve the lowest possible effective doses of both opioids and benzodiazepines per the Board of Medicine Opioid Prescribing Regulations?</p>                                                                                                                                                           | <input type="checkbox"/> YES<br><input type="checkbox"/> NO<br><input type="checkbox"/> N/A, no benzodiazepine therapy |
| <p>9. Has naloxone been prescribed for members with risk factors of prior overdose, substance use disorder, doses in excess of 50 MME/day, antihistamines, antipsychotics, benzodiazepines, gabapentin, pregabalin, tricyclic antidepressants or the "Z" drugs (zopiclone, zolpidem, or zaleplon)?</p>                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> YES<br><input type="checkbox"/> NO<br><input type="checkbox"/> N/A                            |
| <p>10. If member is female between 18-45 years old, has prescriber discussed risk of neonatal abstinence syndrome and provided counseling on contraceptive options?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> YES<br><input type="checkbox"/> NO<br><input type="checkbox"/> N/A                            |

***\*\*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.\****

## **Patient Utilization Management and Safety (PUMS) Program**

Sentara Health Plan has a Patient Utilization Management & Safety (PUMS) program in place. The program makes sure that members are getting the proper health care, especially when it comes to patient safety.

### **PUMS Program Goal:**

PUMS deals with prescription drugs as well as other kinds of health care, making certain the member is getting treatment that is proper and safe. Sentara Health Plans clinical staff reviews our members' use of health care services to see whether they should be in the PUMS program. For members in the PUMS program, Sentara Health Plans takes extra steps to make sure they use services safely.

### **Being considered for PUMS does NOT mean a member has done anything wrong.**

For any member who may be at risk for unsafe services, Sentara Health Plans must review whether the member should be in the PUMS program. In cases involving buprenorphine use, the member will automatically be enrolled in the PUMS program.

### **How Might PUMS Change a Member's Care?**

Sentara Health Plans may offer case management services. Sentara Health Plans could set a single doctor for controlled substances to see the member, or a single pharmacy to provide controlled substance prescription drugs.

**PUMS Member Rights:** Sentara Health Plans will send every PUMS member a letter about the program. The letter will make clear how the member can get emergency care. The letter will also tell them how they can appeal being placed in the PUMS program.

**PLEASE NOTE:** Sentara Health Plans doctors and pharmacists now use the Prescription Monitoring Program (PMP). The PMP helps them make sure that prescription drugs are used safely. Among other Patient Utilization Management & Safety (PUMS) triggers we review patients who have:

**High Average Daily Dose:**  $\geq 90$  cumulative morphine milligram equivalents (MME) per day over the past 90 days.

**AND/OR**

**Concurrent use of Opioids and Benzodiazepines** – at least 1 Opioid claim and 15 day supply of Benzo (in any order).

Our approach is to work collaboratively with patients and providers to ensure safe and appropriate use of controlled substances. We utilize and promote:

- A) PMP Checks
- B) Letters to Doctor & Member
- C) Soft and Hard Pharmacy edits for Benzodiazepine and Opioid utilization
- D) Following CDC Opioid Guidelines
- E) Case Management as appropriate

We greatly appreciate your collaboration and Health Care service to our members. As part of our PUMS safety review we hope to collaborate with you for complete patient information with the goal of validating safe and appropriate controlled substance use and coordinated patient care.

RESPECTFULLY,

Sentara Health Plans CLINICAL STAFF

# Non-opioid Treatment Options for Common Chronic Pain Conditions

## Non-invasive Low back pain treatment recommendations:

- Acute (with or without radiculopathy):
  - 1<sup>st</sup> Line (Non-pharmacologic): Keep in mind excellent natural history of disease. Acupuncture, massage, superficial heat shown to improve pain or function. Also consider Pilates, tai-chi, yoga, psychology referral.
  - 2<sup>nd</sup> Line (pharmacologic): NSAIDs, skeletal muscle relaxer
- Chronic (with or without radiculopathy):
  - 1<sup>st</sup> Line (Non-pharmacologic): Exercise, motor control exercises, tai-chi, yoga, psychology referral, multi-disciplinary rehabilitation, acupuncture, massage
  - 2<sup>nd</sup> Line (pharmacologic): NSAIDs, duloxetine

## Post-herpetic neuralgia:

- Topical (1<sup>st</sup> line for mild pain): 5% lidocaine patch, capsaicin cream or patch
- Systemic: gabapentin, pregabalin\*, amitriptyline, nortriptyline

## Diabetic neuropathy:

- 1<sup>st</sup> Line: pregabalin
- 2<sup>nd</sup> Line: gabapentin, venlafaxine (SNRI), duloxetine, amitriptyline (TCA), capsaicin 0.075% cream

## Fibromyalgia:

- Non-pharmacologic: Patient education (pertaining to lack of disease progression, lack of tissue damage), cognitive behavioral therapy (CBT), and cardiovascular exercise
- Pharmacologic: amitriptyline and cyclobenzaprine (TCAs), duloxetine (SNRI), gabapentin, pregabalin\* (gabapentin), fluoxetine, sertraline, paroxetine (SSRIs)
- No evidence for use of opiates in fibromyalgia

## Migraines:

- Acute Treatment
  - Mild – Moderate: acetaminophen, NSAIDs, caffeine, anti-emetics
  - Severe: triptans, ergots, prochlorperazine, promethazine
- Preventative Treatment
  - Propranolol, timolol, divalproex sodium, topiramate (Level A efficacy)
  - Opiates can cause medication overuse headache

## Osteoarthritis:

- Non-pharmacologic: Exercise, weight loss, water-based exercise, wedged insoles, walking aides, splints
- Pharmacologic: Topical capsaicin, topical NSAIDs (preferred age > 75), oral NSAIDs (non-selective or COX-2 selective), intraarticular corticosteroid injection, consider duloxetine