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):

❑ **Short-Acting Opioid**	❑ **Long-Acting Opioid**	❑ **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

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:** _____

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

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:** _____

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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: **http://www.dhp.virginia.gov/medicine/**

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)**:**

- ❑ HIV/AIDS
- ❑ Chronic back pain
- ❑ Arthritis
- ❑ Fibromyalgia
- ❑ Diabetic neuropathy
- ❑ Postherpetic Neuralgia
- ❑ Other: _____

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

- ❑ Cancer Pain
- ❑ Sickle Cell disease
- ❑ Palliative Care
- ❑ End-of-Life Care
- ❑ Hospice patient

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1. Does prescriber attest that the member has pain associated with cancer, palliative care **(treatment of symptoms associated with life-limiting illnesses)**, sickle cell disease or hospice care? (IF **YES**, please sign and submit, no further information required **UNLESS** a non- preferred/non-formulary drug is prescribed. See **Q6** if non-formulary drug is prescribed.)	❑ YES ❑ NO
2. Is member in remission from cancer and prescriber is safely weaning patient off opioids with a tapering plan? (IF **YES,** please sign and submit, no further information required **UNLESS** a non-preferred/non-formulary drug is prescribed. See **Q6** if non-formulary drug is prescribed.)	❑ YES ❑ NO
3. Is member in a long-term care facility? (IF **YES**, please sign and submit, no further information required **UNLESS** a non-formulary drug is prescribed. See **Q6** if non-formulary drug is prescribed.)	❑ YES ❑ NO
4. Is this medication used to treat? ❑ Acute Pain (less than 90 days) ❑ Post-operative Pain ❑ Chronic Pain (90 days or greater)	❑ YES ❑ NO
5. Please indicate if member has tried and failed any of the following therapies covered **without** PA **(select ALL that apply)**: ❑ Baclofen ❑ tricyclic antidepressant (e.g., nortriptyline) ❑ NSAIDs (oral) ❑ Capsaicin Gel ❑ gabapentin ❑ Lidocaine 5% Patch ❑ duloxetine ❑ Cognitive behavioral therapy (CBT) ❑ Physical Therapy ❑ Other: _____	
6. If requesting a **non-preferred** drug (i.e., Avinza®, Kadian®, Embeda®), has member tried and failed an adequate trial of **two (2)** different **Preferred** drugs? If **YES**, please list drug name, length of trial, and reason for discontinuation: _____ _____ _____	❑ N/A product is preferred ❑ YES ❑ NO

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

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7. Provide member's Active Daily MME from the PMP (https://virginia.pmpaware.net/login) **MME**: _____ • 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?	❑ YES ❑ NO ❑ N/A, MME is less than 90
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?	❑ YES ❑ NO ❑ N/A (no benzodiazepine therapy)
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)?	❑ YES ❑ NO ❑ N/A
10. If member is female between 18-45 years old, has prescriber discussed risk of neonatal abstinence syndrome and provided counseling on contraceptive options?	❑ YES ❑ NO ❑ 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.****

REVISED/UPDATED/REFORMATTED: ~~7/5/2017; 8/9/2017; 1/2/2018; 8/28/2018; 6/4/2019; 1/2/2020; 6/30/2021; 6/28/2022; 3/2/2023, 6/28/2023;~~ **3/24/2025**