Government of District of Columbia Department of Health Care Finance

Short and Long Acting Opioids Morphine Milligram Equivalent (MME)

Initial Prior Authorization Request

REQUEST DATE: / /

PATIENT INFORMATION

PATIENT'S MEDICAID ID NUMBER

PATIENT'S DATE OF BIRTH / /

PATIENT'S FULL NAME

PRESCRIBER INFORMATION

PRESCRIBER'S FULL NAME

PRESCRIBER PHONE NUMBER: - -

PRESCRIBER FAX NUMBER: - -

PRESCRIBER SPECIALTY:

PRESCRIBER NPI #: -

Short and long acting opioids are indicated for moderate-severe pain, non-responsive or inadequately responsive to non-pharmacologic treatment (e.g. PT, pain psychology, alternative treatments) and/or non-opioid analgesic treatment (e.g. NSAIDs, APAP, gabapentin, lidocaine patch, muscle relaxers). Please refer to FDA approved product information for prescribing details and approved indications.

INFORMATION REQUIRED FOR PRIOR AUTHORIZATION APPROVAL

1. **Is the patient 18 years of age or older?** ☐ Yes ☐ No
2. **Drug Name/ Strength:** _____
3. **Directions:** _____ **Quantity:** _____
4. **Patient has a diagnosis of** _____
5. **Does prescriber attest that the patient has intractable pain associated with active cancer, palliative care or hospice care?** ☐ Yes ☐ No
6. **Patient has tried and failed non-opioid analgesic treatment? If yes, please explain**_____
7. **Does the patient's pain significantly impair their physical functioning (e.g. ADL's, sleep, work)?** ☐ Yes ☐ No
8. **Document most recent date the provider checked the District's Prescription Monitoring Service (PDMP) for this patient:** ___/____/____
9. **Patient has documented history of opioid addiction or abuse?** ☐ Yes ☐ No
10. **Is the patient currently being treated for opioid addiction?** ☐ Yes ☐ No
11. **Prescriber attests that a treatment plan with goals that address benefits and harm has been established with patient.** ☐ Yes ☐ No
12. **Has the prescriber ordered and reviewed a urine drug screen (UDS) or serum medication level prior to initiating treatment with short or long-acting opioids within the past 30 days?** ☐ Yes ☐ No
13. **Patient has been counseled regarding the risks of becoming pregnant while receiving this medication, including the risk of neonatal abstinence syndrome?** ☐ Yes ☐ No
14. **Does the patient have moderate-severe pain requiring around-the-clock analgesia for an extended period?** ☐ Yes ☐ No

    If yes, explain_____
15. **Has the patient tried and failed an adequate opioid trial at a lower Morphine Milligram Equivalent (MME) dose?** ☐ Yes ☐ No
16. **Is the prescription written by or has the prescriber consulted with a pain specialist or a prescriber specializing in the same organ system as the primary pain diagnosis?** ☐ Yes ☐ No

I certify that, to the best of my knowledge, all information I have provided on this request is complete and factual.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____