Alaska Medicaid

Extended Release Opioids Prior Authorization Request Form

Must be accompanied with signed Opioid Agreement

Criteria and Forms are available at the website: http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx

Fax this signed, completed form with required attachments to: (888) 603-7696 **Questions?** Call (800) 331-4475

Note: morphine sulfate ER TABLETS and fentanyl transdermal do not require PA when used within quantity limits. Reformatted 8/1/13

REQUESTOR	Requestor Name	Title
RECIPIENT	Last Name, First Name, Middle I.:	
DOB:	Recipient ID:	Sex: ☐ Male ☐ Female
PRESCRIBER	Name:	NPI:
Phone:		Fax:
Specialty:		
REQUEST	Drug:	Strength: Dosage Form:
Diagnosis Requiring ER Opioid Therapy:		Dosage schedule:
Other Diagnoses:		QTY: Day Supply:
REQUIRED (All items must be completed/submitted)		Requested Start Date:

1) Patient is opioid tolerant and has taken at least one of the following (Please check all that apply)

☐ **60** mg **oral morphine per day** ☐ **25mcg transdermal fentanyl/hour** ☐ **30mg oral oxycodone per day**

☐ **8 mg oral hydromorphone per day** ☐ **25mg oral oxymorphone** ☐ **An equianalgesic dose of any other opioid for a week or longer**

Please detail previous/current therapies with treatment dates: _____

_____

2) Request must be accompanied by a signed opioid agreement or "pain contract". ☐ **Copy Attached**

3) Patient must have tried morphine ER TABLETS or fentanyl transdermal patches at an equivalent therapeutic dose that resulted in a documented adverse reaction, treatment failure, or other medical complication within past year OR provide medical rationale for non trial with morphine ER tablets or fentanyl transdermal. Please provide therapies with treatment dates.

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4) Request must be accompanied by a Letter of Medical Necessity OR clear, concise, detailed information that describes the need for an around-the-clock opioid analgesic

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***** Please note: If prior authorization exists for another extended release opioid it will be ended if the new request is approved.**
***** The Alaska Prescription Drug Monitoring Program can be accessed at:** http://www.alaskapdmp.com/

Signature of submitter _____ Date:_____

By signing this form, the prescriber is attesting that documentation supporting the above information is recorded in the Patient's Medical Chart.

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.