Alaska Medicaid Opioid TD, QL, Extended Release and Second-Level Opioid Review Prior Authorization Form

Fax this request to: **1-888-603-7696** Questions: **Call Magellan Medicaid Administration at 800-331-4475**

Or mail this request to: **Medicaid PA Unit, 14100 Magellan Plaza, Maryland Heights, MO 63043**

Note: This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before submitting this form. 2015/05

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

Form available at: http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx

Member Information

LAST NAME: **FIRST NAME:**

ID NUMBER: **DATE OF BIRTH:** – – **GENDER** M F

Prescriber Information

LAST NAME: **FIRST NAME:**

NPI NUMBER: **SPECIALTY:**

PHONE NUMBER: – – **FAX NUMBER:** – –

Pharmacy Information

NAME: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

Requested Opioid (Drug1) / Strength / Dosage Form / Schedule

Requested Opioid (Drug2) / Strength / Dosage Form / Schedule *(if applicable, therapeutic duplication requests)*

Quantity & Day Supply (Drug1)	***Quantity & Day Supply (Drug2)***	***Diagnosis*** *(for which opioids are requested)*

Requested Prior Authorization Start Date
☐ When approved ☐ Specific Date — / /

Requested Prior Authorization Duration
number of months requested

Reason for Request
- ☐ Product Selection, extended-release (ER) opioid
- ☐ Therapeutic Duplication (TD), short or ER opioid
- ☐ Exceed Quantity Limit (QL), short or ER opioid
- ☐ Second-Level Opioid Review: ☐ TD ☐ QL ☐ Other

Patient is opioid tolerant
☐ Yes ☐ No *Years/Months* /

Current Medication List (☐ **see attached**) ALL
must include all medications, doses, and sig regardless of payment source

Calculated total daily Morphine Equivalent Dose (MED) ALL
http://agencymeddirectors.wa.gov/mobile.html
from all opioids, including prn, from all prescribers (regardless of payment source)

Medical Justification *(attached)*
- ☐ Letter of Medical Necessity ALL
- ☐ Pain Contract ALL
- ☐ Treatment plan, pain mgmt RW
- ☐ Pain Specialist notes RW
- ☐ Chart notes (6 months required for second-level review requests) RW
- ☐ Medical rationale for non-trial of preferred agents, attached RW

Previously trialed opioid agents RW	***Daily Dose***	***Inclusive Dates***	***Reason for discontinuation***

ALL required for all requests

RW required when necessary to demonstrate clinical justification and for all requests that require second level review

Prescriber Signature (Required) ***Date***

By signature, the Prescriber confirms the above information is accurate and verifiable by patient records

Information regarding Second-level Reviews

Prior authorization requests requiring second-level reviews will be escalated to the State of Alaska for review by a physician who has completed a residency in anesthesiology and an ACGME accredited subspecialty fellowship in pain medicine. Once all required information has been received, please allow several working days for the State to review.

Second-level reviews may be requested for:

- Review of a previous denial decision of quantity limit exceptions or therapeutic duplications
  http://dhss.alaska.gov/dhcs/Pages/pharmacy/medpriorauthoriz.aspx
  http://manuals.medicaidalaska.com/docs/dnld/AKRx_letter_Opioid_Theraputic_Duplication_Edits_02102012.pdf
- Exceptional circumstances

Prescribers submitting documentation for second-level review requests should ensure that the following documentation is attached:

☐ Letter of medical necessity from the prescriber detailing the need for prescribed therapy, including all medications the recipient is taking ***(required)***.

☐ Documentation of previous treatment failures including start and stop dates and the last 6 months of progress notes ***(required)***.

☐ Pain management treatment plan including a copy of the current pain contract or opioid agreement ***(required)***.

☐ Documentation from a pain specialist supporting the prescribed therapy.

☐ Whether patient is new to Medicaid with no previous Medicaid claims for requested or other pain medication(s).

The State of Alaska will contact the Magellan Clinical Call Center and the prescriber will be advised of the determination once the submitted documentation has been evaluated by the reviewing physician. If the request is denied the prescriber will be provided with an opportunity to speak with the physician reviewer to discuss the determination or provide additional information.

Please ensure ALL required documents are included in your faxed request [888-603-7696].

Additional Resources:

- State of Alaska Prescription Drug Monitoring Program:
  http://www.alaskapdmp.com/
- Example pain contracts from the NIH NIDA may be found at:
  http://www.drugabuse.gov/sites/default/files/files/SamplePatientAgreementForms.pdf
- Opioid and Pain Management CMEs/CEs from the NIH NIDA may be found at:
  http://www.drugabuse.gov/opioid-pain-management-cmesces