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Magellan Rx MANAGEMENT℠

**NYRx the Medicaid Pharmacy Program**

# Opioid Agents Prior Authorization Worksheet

**Fax Number: 1-800-268-2990**

Processing may be delayed if information submitted is illegible or incomplete. If your fax includes the standardized fax form, only the **Member Name**, **DOB**, **ID**, and **Clinical Criteria** need to be completed and faxed as an attachment to process your request.

## ENROLLEE INFORMATION

**Enrollee's Last Name:** _____

**Enrollee's First Name:** _____

**Date of Birth:** _____

**Enrollee's Medicaid ID (2 letters, 5 numbers, 1 letter):** _____

## PRESCRIBER INFORMATION

**Prescriber's Last Name:** _____

**Prescriber's First Name:** _____

**National Provider Identifier (NPI) Number:** _____

**Board Certified Specialty:** _____

**Prescriber's Street Address:** _____

**City:** _____

**State:** _____ **Zip Code** _____

**Prescriber's Phone Number:** _____

**Prescriber's Fax Number:** _____

## REQUESTED DRUG INFORMATION

**Drug Name:** _____ **Drug Strength:** _____

**Quantity:** _____ **Refills:** _____

**Directions:** _____

**New Prescription:** ☐ Yes ☐ No If **NO**, date therapy was initiated: _____

Has the prescriber reviewed the NYS Prescription Monitoring Program (I-STOP)?

☐ Yes ☐ No

Does the patient have access to naloxone?

☐ Yes ☐ No

**Enrollee's Last Name:** **Enrollee's First Name:**

## CLINICAL CRITERIA – PRESCRIPTION FILL/REFILL LIMIT

Does the patient have chronic pain?

☐ Yes ☐ No

**Diagnosis:** _____

1. Patients are limited to a total of four opioid prescription fills per rolling 30 days. What is the clinical rationale for exceeding four fills of any opioid prescription per month?

2. Please provide current long-acting and short-acting opioid therapy:

| Medication | Start Date | Strength | Frequency | Discontinuation Date |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## PREFERRED DRUG LIST

1. Is a non-preferred opioid agent being prescribed? (Please refer to the PDL at https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf for a current list of preferred and non-preferred agents.)

   ☐ Yes ☐ No

   If **YES**, please select the most appropriate clinical rationale (questions 2 through 5) for use of a non-preferred agent (form cannot be processed without required explanation).

2. Patient has experienced a treatment failure with a preferred drug.

   ☐ Yes ☐ No

3. Patient has experienced an adverse drug reaction with a preferred drug.

   ☐ Yes ☐ No

4. There is documented history of successful therapeutic control with a nonpreferred drug and transition to a preferred drug is medically contraindicated.

   ☐ Yes ☐ No

5. Other (Please specify the clinical reason the patient is unable to use a preferred agent in the same drug class. If necessary, fax additional pages):

**Enrollee's Last Name:** **Enrollee's First Name:**

## CLINICAL DRUG REVIEW PROGRAM: FENTANYL MUCOSAL AGENTS

Drug name:

☐ fentanyl buccal ☐ Fentora® (fentanyl buccal tablet)

☐ fentanyl lozenge (generic for Actiq®)

### For Fentanyl Lozenge, Fentanyl buccal tablet (Fentora®)

1. Is this medication being prescribed to manage breakthrough cancer pain?
   ☐ Yes ☐ No If **NO**, list diagnosis: _____
2. Are you or have you consulted with an Oncologist or Pain Management Specialist?
   ☐ Yes ☐ No
3. Is the patient already receiving long-acting opioid therapy for underlying persistent pain?
   ☐ Yes ☐ No If **NO**, provide clinical reason: _____
4. Is the patient tolerant[1] to the opioid therapy currently being used for his/her underlying persistent pain?
   ☐ Yes ☐ No If **NO**, provide clinical reason: _____

## CLINICAL EDITS

**Applies to all short-acting opioids (SAO), long-acting opioids (LAO), Tramadol ER products, Methadone, Soma compound w/codeine, and Fentanyl Mucosal Agents:**

1. Has the patient's risks for opioid misuse or abuse been assessed?
   ☐ Yes ☐ No
2. Document measures taken to monitor for misuse or abuse (i.e., regular Prescription Monitoring Program [PMP] checks, pill count, urine drug screen, pharmacy check):

3. New York State Public Health Law requires co-prescribing of an opioid antagonist when an opioid is prescribed for someone with a history of substance use disorder. Have you considered co-prescribing an opioid antagonist?
   ☐ Yes ☐ No If **NO**, provide clinical reason: _____

[1] Patients are considered opioid-tolerant if they are taking around-the-clock medicine for one week consisting of at least:

- 60 mg of morphine;
- 25 mcg transdermal fentanyl/hour;
- 30 mg of oxycodone;
- 8 mg of oral hydromorphone; or
- Equianalgesic dose of another opioid daily for a week or longer.

**Enrollee's Last Name:** **Enrollee's First Name:**

## CLINICAL EDITS *(CONTINUED)*

### Tramadol and Codeine-containing Products

1. Is the patient being prescribed tramadol or codeine 12 years of age or younger?
   ☐ Yes ☐ No

   If **YES**, what is the clinical reason for prescribing a codeine or tramadol containing product in a patient < 12-years-old despite the contraindications and warnings listed in the manufacturer package insert for this age group?

## STEP THERAPY

### Nucynta® ER (Long-Acting Opioid)

1. Is the patient naïve to long acting opioid therapy?
   ☐ Yes ☐ No
2. If **YES**, has your patient experienced a treatment failure or adverse reaction to Nucynta IR (immediate release)?
   ☐ Yes ☐ No

### Nucynta® IR (Short-Acting Opioid)

1. Has your patient experienced a treatment failure or adverse reaction to tramadol plus one other preferred short-acting opioid?
   ☐ Yes ☐ No

### Tramadol ER (Generic of Ultram ER)

1. Has your patient experienced a treatment failure or adverse reaction to immediate release tramadol?
   ☐ Yes ☐ No
2. If **NO**, is the prescriber willing to change?
   ☐ Yes ☐ No

### ConZip (tramadol ER)

1. Has your patient experienced a treatment failure or adverse reaction to immediate release tramadol?
   ☐ Yes ☐ No
2. Has your patient experienced a treatment failure or adverse reaction to tramadol ER (generic of Ultram ER)?
   ☐ Yes ☐ No
3. If **NO**, is the prescriber willing to change?
   ☐ Yes ☐ No

**Enrollee's Last Name:** **Enrollee's First Name:**

## STEP THERAPY *(CONTINUED)*

### Methadone Products

1. Is Methadone being prescribed for the treatment of opioid addiction?
   ☐ Yes ☐ No If **YES**, Methadone must be billed through a Methadone maintenance treatment program.
2. Has your patient experienced a treatment failure or adverse reaction to a long acting opioid?
   ☐ Yes ☐ No

## THERAPEUTIC DUPLICATION

### Two Long-acting Opioids (Applies to LAO, Tramadol ER Products, and Methadone)

1. What is the clinical rationale for the patient requiring concurrent use of two or more long-acting opioids?

2. Please list long-acting opioid(s):

### Opioid/Benzodiazepine (Applies to All SAO and LAO, Tramadol ER Products, Methadone, Soma Compound with Codeine, and Fentanyl Mucosal Agents)

1. Are you aware that concurrent use of an opioid and benzodiazepine can increase the risk of respiratory depression and other adverse events?
   ☐ Yes ☐ No
2. Are you monitoring for these adverse events?
   ☐ Yes ☐ No
3. What is the clinical rationale for the patient requiring concurrent use of a benzodiazepine and an opioid?

4. Please list the benzodiazepine product(s):

5. New York State Public Health Law requires co-prescribing of an opioid antagonist when an opioid and benzodiazepine are prescribed concurrently. Have you considered co-prescribing an opioid antagonist?
   ☐ Yes ☐ No

   If **NO**, provide clinical reason:

**Enrollee's Last Name:** **Enrollee's First Name:**

## THERAPEUTIC DUPLICATION *(CONTINUED)*

### Opioid/Buprenorphine (Applies to All SAO and LAO, Tramadol ER Products, Methadone, Soma Compound with Codeine, and Fentanyl Mucosal Agents)

1. Is the patient currently taking a Buprenorphine product?
   ☐ Yes ☐ No
2. Are you willing to prescribe a non-opiate analgesic (i.e., NSAID, etc.)?
   ☐ Yes ☐ No
3. Is the patient having surgery or had an acute event requiring narcotic pain medication?
   ☐ Yes ☐ No
4. What is the clinical rationale for the patient requiring concurrent use of an opioid and a buprenorphine product?

### Opioid/Gabapentinoids (Applies to All SAO)

1. Are you aware that concurrent use of an opioid and gabapentin or pregabalin can increase the risk of respiratory depression and other serious adverse events?
   ☐ Yes ☐ No
2. Are you monitoring for these adverse events?
   ☐ Yes ☐ No
3. What is the clinical rationale for the patient requiring concurrent use of gabapentin or pregabalin and an opioid?
4. Please list the gabapentinoid product(s):

### Opioid + CNS Stimulant (Applies to All SAO )

1. What is the clinical rationale for the patient requiring concurrent use of a CNS stimulant and an opioid?
2. List the name of the CNS stimulant the patient is currently on: _____
3. Concurrent use of an opioid and CNS stimulant may lead to synergistic effects, which may cause euphoric effects and increased risk for dependence, adverse events (e.g., serotonin syndrome, overdose), and death. Are you aware of this risk and is the patient being monitored for these adverse events?
   ☐ Yes ☐ No

**Enrollee's Last Name:** **Enrollee's First Name:**

## MORPHINE MILLIGRAM EQUIVALENCE EDIT (MME) – APPLIES TO ALL OPIOIDS

1. Provide the total MME for the medication being requested: _____
2. Provide the total MME for all opioids combined: _____
3. Is the patient established on this regimen?
   ☐ Yes ☐ No If **YES**, provide the start date: _____
4. For opioid-naïve patients with acute pain:
   a. If the total MME exceeds 50 MME/day, what is the clinical reason for prescribing a high MME regimen?

   b. Are you willing to prescribe a lower MME regimen?
      ☐ Yes ☐ No
   c. If **YES**, provide regimen:

5. For opioid-tolerant patients with non-acute pain (> 7 days):
   a. If the total MME exceeds 90 MME/day, what is the clinical reason for prescribing a high MME regimen?

   b. Are you willing to prescribe a lower MME regimen?
      ☐ Yes ☐ No
   c. If **YES**, provide regimen:

6. New York State Public Health Law requires co-prescribing of an opioid antagonist when an opioid is prescribed for someone on high dose or cumulative prescriptions that result in ninety morphine milligram equivalents or higher per day. Have you considered co-prescribing an opioid antagonist?
   ☐ Yes ☐ No
   If **NO**, provide clinical reason:

**Enrollee's Last Name:** **Enrollee's First Name:**

## FREQUENCY/QUANTITY/DURATION (F/Q/D)

### For LAO, Methadone, and Tramadol ER Products

1. For an initial fill for an opioid-naïve patient, please provide a clinical rationale for requesting a long-acting opioid in an opioid-naïve patient.

### For SAO Only

1. New York State Public Health Law prohibits a practitioner from prescribing more than a 7-day supply of an opioid for acute pain in an opioid-naïve patient. What is the clinical rationale for exceeding the 7-day supply initial fill duration limit?

### For SAO Only (for Requests That Exceed the 90-day Duration Limit)

1. Are you currently tapering the patient off their short-acting narcotic and attempting to utilize different treatment options? (Alternative non-opioid options can be found at: https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf)
   ☐ Yes ☐ No
2. Is the patient currently on a long-acting opioid that is being optimized for treatment of the patient's diagnosis?
   ☐ Yes ☐ No
3. Has your patient experienced a treatment failure or adverse reaction to a long-acting opioid or is there a contraindication to using a long-acting opioid?
   ☐ Yes ☐ No
4. Has the patient's risk for opioid misuse or abuse been assessed?
   ☐ Yes ☐ No

**Enrollee's Last Name:** **Enrollee's First Name:**

## FREQUENCY/QUANTITY/DURATION (F/Q/D) *(CONTINUED)*

### For Methadone Requests that Exceed Max of #12 Units per Day, or #360 Units per 30 Days

1. Has the patient been assessed for clinical risks of opioid/substance abuse/addiction?
   ☐ Yes ☐ No
2. Does the patient have an underlying cardiovascular disorder or history of cardiac arrhythmias?
   ☐ Yes ☐ No
3. Will the patient periodically be clinically assessed for the need for gradual dosage adjustments?
   ☐ Yes ☐ No
4. What is the clinical rationale for the patient requiring a dose exceeding #12 units per day?

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

**Fax Number:** 1-800-268-2990

**Billing Questions:** 1-800-343-9000

For clinical concerns or Preferred Drug Program questions, please visit http://newyork.fhsc.com or call 1-877-309-9493.