MARYLAND Department of Health

OPIOID PRIOR AUTHORIZATION FORM

Managed care organizations listed and Medicaid fee-for-service use this form for opioid prior authorization.

Updated October 2017

Fax completed forms to the number corresponding to the patient's plan:

MCO and Fee-for-Service	Telephone	Fax
Aetna Better Health of Maryland (ABHM)	(866) 827-2710	(877)-270-3298 or www.aetnabetterhealth.com/maryland
Jai Medical Systems (JMS)	(800) 555-8513	(800) 583-6010
Kaiser Permanente Health Choice (KP)	(866) 331-2103	(866) 331-2104
Maryland Medicaid Fee-for-Service (FFS)	(800) 932-3918	(866) 440-9345
Maryland Physicians Care (MPC)	(800)-753-2851	(877)-251-5896
MedStar Family Choice (MFC)	(410) 933-2200 or 800-905-1722 After hours: (410)-999-5525	(888) 243-1790 or (410) 933-2274
Priority Partners (PP)	(888) 819-1043, option 4	(410)-424-4751
University of MD Health Partners (UMHP)	(877) 418-4133	(855) 762-5205 or www.covermymeds.com/epa/caremark

For Amerigroup and UnitedHealthCare forms visit:
https://mmcp.health.maryland.gov/healthchoice/opioid-dur-workgroup/Pages/pa-information.aspx

ALL prescribers must complete SECTION 1, SECTION 2 and SECTION 3.

Prescribers must complete either SECTION 4 or SECTION 5 as appropriate.

TO AVOID DELAYS in processing this request, please ensure that contact information is accurate in case additional information is required.

Duration of prior authorization is determined by Medicaid fee-for-service of managed care organizations.

For additional information about individual managed care organizations opioid prescribing requirements, visit: http://mmcp.health.maryland.gov/healthchoice/opioid-dur-workgroup/pages/pa-information.aspx.

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SECTION 1: DEMOGRAPHICS

Date: _____

Patient Name: _____

MCO Plan ID#: _____ [Required for UMHP, KP, MFC]

MD Medicaid ID#: _____ [Required for ABHP, FFS, JMS, MPC, PP]

Date of Birth: _____ Gender as listed by the patient: Male Female

Name of MCO: _____ Other Insurance? _____

Prescriber Name: _____ Prescriber NPI#: _____

Prescriber DEA#: _____ Phone for Prescriber: _____

Office Contact Name/Fax Attention to: _____

Office Contact Direct Phone#:_____ Office / Prescriber Fax#:_____

Facility / Clinic Name (if applicable): _____

SECTION 2: CHECK ALL BOXES THAT APPLY

☐ Non-Urgent Review

☐ Urgent Review: By checking this box, I certify that applying non-urgent review timeframe may lead to patient harm.

☐ Yes No This patient is currently an inpatient at an acute care hospital.

☐ Yes No Is this patient being discharged from the hospital or ED?

☐ Yes No Is the patient pregnant? *(See references below)*

1) http://www.medscape.com/viewarticle/867512
2) https://www.cdc.gov/mmwr/volumes/65/wr/mm6531a2.htm
3) https://www.fda.gov/Drugs/DrugSafety/ucm549679.htm
4) https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm118113.htm?source=govdelivery

Continue to Section 3

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SECTION 3: USE A SEPARATE FORM FOR EACH MEDICATION BEING REQUESTED

Select One: ☐ New Prescription ☐ Refill (i.e., patient has been taking medication)

Diagnosis:_____

Select All That Apply:

☐ Immediate-Release Opioid ☐ Extended-Release Opioid ☐ Fentanyl ☐ Methadone (for pain)

☐ Exceeds 90 MME/day ☐ Exceeds Tablet Quantity Limit (Maximum Daily Limit)

If 90 MME/day or Quantity Limit is exceeded, provide rationale:_____

_____

_____

☐ Non-Formulary/Non-Preferred. If selected, complete information within table below.

Previous Formulary Trial(s)		
Drug Name/Strength/Dose	Date(s) & Duration of Trial	Treatment Outcome

Drug Requested:

Drug Name:_____ Strength:_____ Quantity:_____

SIG:_____ Length of Treatment:_____ ☐Day(s) / ☐Month(s)

SECTION 4: FOR EXEMPT PATIENTS ONLY

Yes	No	Active Cancer Treatment	Cancer Type:_____
Yes	No	Sickle Cell Disease	
Yes	No	Hospice Care	Diagnosis: _____
Yes	No	Palliative Care [(Diagnosis Code (Z51.5)]	Diagnosis: _____
Yes	No	Long-Term Care / Skilled Nursing Facility	

I certify that the benefits of opioid treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber Signature:_____ Date:_____

Important: The remainder of this PA form does not need to be completed for patients who meet at least one of the above exemptions in SECTION 4.

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SECTION 5: ATTESTATION REQUIRED OF ALL PRESCRIBERS FOR NON-EXEMPT PATIENTS
Choose the section (A. or B.) that applies.

A. For Outpatient Prescribers providing ongoing care:

EACH Question Must Be Answered

Yes No Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
Yes No Patient has/will have random Urine Drug Screens (UDS).
Yes No Naloxone prescription was provided or offered to patient/patient's household.
Yes No Patient-Prescriber Pain Management/Opioid Treatment Agreement signed and in medical record.

B. For Inpatient Hospital (Hospital), Ambulatory Surgery Center (ASC), and Emergency Room (ER) Prescribers:

EACH Question Must Be Answered

Yes No Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
Yes No Naloxone prescription provided or offered to patient/patient's household.
Yes No I have discussed the risks/benefits associated with opioid use with patient/patient's household.
Yes No The patient is exempt from need for a Patient-Prescriber Pain Management/Opioid Treatment Agreement and random UDS, because he/she is being discharged from the Hospital/ASC/ER and opioid treatment prescribed by the discharging provider will be for less than 30 days or the need for further opioid use will be re-evaluated by an Outpatient provider within 30 days.

I certify that the benefits of opioid treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber Signature:_____ Date:_____

Important: Incomplete attestations will not be able to be processed by Medicaid fee-for-service or managed care organization and will delay requests.

FOR INTERNAL USE ONLY

Duration of Approval:_____ Authorized By/Date:_____