OPIOID PRIOR AUTHORIZATION FORM

Incomplete forms will not be reviewed

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

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

MCO and Fee-for-Service	Telephone	Fax
Aetna Better Health of Maryland	1-866-827-2710	1-877-270-3298 or www.aetnabetterhealth.com/maryland
CareFirst Blue Cross Blue Shield Community Health Plan Maryland	1-877-418-4133	1-855-762-5205 OR CVS Caremark Prior Authorization Forms | CoverMyMeds
Jai Medical Systems	1-800-555-8513	1-866-999-7736 OR 1-800-583-6010
Kaiser Permanente Health Choice	1-866-331-2103	1-866-331-2104
Maryland Medicaid Fee-for-Service	1-800-932-3918	1-866-440-9345
Maryland Physicians Care	1-888-258-8250	1-833-896-0656
MedStar Family Choice	1-877-772-6505	410-350-7454
Priority Partners	1-888-819-1043	410-424-4607
United Healthcare Community Plan	1-800-310-6826	1-866-940-7328
WellPoint Maryland	1-833-707-0867	1-844-490-4871

For Amerigroup and UnitedHealthcare forms visit:

https://health.maryland.gov/mmcp/pap/Pages/Pharmacy-Program-Forms.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:

https://health.maryland.gov/mmcp/pap/Pages/Pharmacy-Program-Forms.aspx

Maryland
DEPARTMENT OF HEALTH

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SECTION 1: DEMOGRAPHICS

Date (mm/dd/yyyy): _____

Patient name: _____

MCO Plan ID: _____

MD Medicaid ID: _____

Date of Birth (mm/dd/yyyy): _____ 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 THE 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/PostmarketDrugSafetyInformationforPatientsandProviders/ucm118113.htm

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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: _____

Previous Formulary Trial(s)

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

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

Quantity: _____ Length of Treatment: Day(s) _____ Month(s): _____

SIG: _____

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

Important: The remainder of this PA form does not need to be completed for patients who meet at least one of the above exceptions

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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 was provided or offered to patient/patient's household.

❑ Yes ❑ No I have discussed the risks/benefits associated with opioid use with patient/patient's house- hold

❑ 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.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber Signature: _____ Date (mm/dd/yyyy): _____

Important: Incomplete attestations will not be able to be processed by Medicaid Fee-For-Service (FFS) or Managed Care Organization (MCO) and will delay requests.