

# Prior Authorization Form

## Acute Use Up to 15-Day Supply

Access this PA form at [https://tenncare.magellanhealth.com/static/docs/Prior\\_Authorization\\_Forms/TennCare\\_Acute\\_Opioid\\_PA\\_Form.pdf](https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_Acute_Opioid_PA_Form.pdf)

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

### Member Information

<b>LAST NAME:</b> <input style="width: 100%; height: 20px;" type="text"/>	<b>FIRST NAME:</b> <input style="width: 100%; height: 20px;" type="text"/>
<b>ID NUMBER:</b> <input style="width: 100%; height: 20px;" type="text"/>	<b>DATE OF BIRTH:</b> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 40px; height: 20px;" type="text"/>

### Prescriber Information

<b>LAST NAME:</b> <input style="width: 100%; height: 20px;" type="text"/>	<b>FIRST NAME:</b> <input style="width: 100%; height: 20px;" type="text"/>
<b>OFFICE ADDRESS:</b> <input style="width: 100%; height: 20px;" type="text"/>	
<b>CITY:</b> <input style="width: 100%; height: 20px;" type="text"/>	<b>STATE:</b> <input style="width: 20px; height: 20px;" type="text"/>
<b>NPI NUMBER:</b> <input style="width: 100%; height: 20px;" type="text"/>	<b>DEA NUMBER:</b> <input style="width: 100%; height: 20px;" type="text"/>
<b>PHONE NUMBER:</b> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 40px; height: 20px;" type="text"/>	<b>FAX NUMBER:</b> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 40px; height: 20px;" type="text"/>

Is the prescriber a TennCare provider with a Medicaid ID?  Yes  No

Is the prescriber a single-patient contract holder for this patient?  Yes  No

**TennCare Rule: 1200-13-13-.04(1)(c)12 confines acute narcotic prescription coverage for non-chronic opioid users up to a maximum of 15 days in any 180-day period not to exceed 60 MME per day. The first-fill prescription cannot exceed 5-days. Prior Authorization is required for all subsequent acute prescriptions after the first-fill. Information and separate PA forms for clinical exceptions (e.g. burn or corrosion, sickle cell disorder, use in LTC facilities, and cancer undergoing active treatment, hospice care) can be found on the Magellan TennCare website at: <https://tenncare.magellanhealth.com>**

**Requests for Acute Opioid Users are limited to 60 MME/day.**

Go to the following link to see the most current Morphine Milligram Equivalent Conversion Chart:  
[https://tenncare.magellanhealth.com/static/docs/Program\\_Information/TennCare\\_MME\\_Conversion\\_Chart.pdf](https://tenncare.magellanhealth.com/static/docs/Program_Information/TennCare_MME_Conversion_Chart.pdf)

<b>Drug Name:</b> _____ Preferred agents: codeine/APAP, Endocet, hydrocodone/APAP, hydrocodone/IBU, hydromorphone, morphine IR, oxycodone, oxycodone/APAP, tramadol <input type="checkbox"/> *Non-preferred agent (specify) here: _____	<b>Please calculate all short-acting narcotic agents and dosages with MME conversion (see link above) that the patient may be receiving below to obtain the total daily MME amount.</b> <b>Daily MME Formula:</b> (MME/Unit x # Units for Prescription)/Day's Supply of Prescription
<b>Strength:</b> _____ <b>Directions:</b> _____ <b>Quantity Requested:</b> _____	PLEASE LIST all Short and Long-acting opioids patient is currently taking: Drug Name; strength _____ Daily MME _____ Drug Name; strength _____ Daily MME _____ Drug Name; strength _____ Daily MME _____ Drug Name; strength _____ Daily MME _____ Drug Name; strength _____ Daily MME _____ <input type="checkbox"/> <b>Total Daily MME patient currently receiving for all opioid agents:</b> _____

\*With the exception of the "Branded Drugs Classified as Generics" list, TennCare is a mandatory generic program in accordance with state law (TCA 53-10-205). Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated on the PDL.  
[https://tenncare.magellanhealth.com/static/docs/Preferred\\_Drug\\_List\\_and\\_Drug\\_Criteria/TennCare\\_PDL.pdf](https://tenncare.magellanhealth.com/static/docs/Preferred_Drug_List_and_Drug_Criteria/TennCare_PDL.pdf)

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Acute Use Up to 15-Day Supply**

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**Clinical Criteria Documentation**

\*\*\*\*Do not include documentation that is not requested on this form\*\*\*\*

1. Does the patient have moderate-severe acute pain requiring treatment beyond an initial first-fill opioid prescription?  Yes (indicate diagnosis below)  No

Diagnosis (specify and list ICD-10): \_\_\_\_\_

2. Have non-pharmacologic therapies been considered?  Yes  No  
 3. Has the patient tried non-opioid analgesic treatment? (if "yes" document below with responses)  Yes  No

Non-Opioid Analgesic	Dates	Response

4. Does the patient's pain significantly impair their physical functioning (e.g., ADL's, sleep, work)?  Yes  No  
 5. Is the patient currently being treated for opioid addiction?  Yes  No

**The overutilization of opioid analgesics has been associated with increased risk of opioid used disorder and overdose.**

6. For patients >18 years of age, has the provider assessed the member using a Screening, Brief Intervention, and Referral to Treatment (SBIRT) Questionnaire (e.g., SBIRT survey)?  Yes  No  
 7. For patients 11–18 years of age, has the provider assessed the member using an adolescent Screening, Brief Intervention, and Referral to Treatment (SBIRT) Questionnaire (e.g., CRAFFT Survey)?  Yes  No  
 8. Will this patient be using benzodiazepines and opioids concomitantly?  Yes  No  
 9. **IF YES**, is the patient under the care of or been referred to a mental health provider?  Yes  No  
 10. For requests for non-preferred agents, does the patient have a reason they cannot use a preferred agent?  Yes  No  
 If yes, provide details below:

**For female patients between the ages of 14 and 44, please complete questions 11-15. For male patients, go to signature section.**

11. The use of opioid analgesics during pregnancy has been associated with neonatal abstinence syndrome. Has this patient been counseled regarding the risks of becoming pregnant while receiving this medication, including the risk of neonatal abstinence syndrome?  Yes  No  
 12. Is this patient pregnant?  Yes  No  
 13. Is this patient currently utilizing a form of contraception (e.g. barrier, oral contraceptive, rhythm method)?  Yes  No  
 14. Does this patient have an intrauterine device (IUD) or implant?  Yes  No  
 15. Does this patient have a history of hysterectomy, tubal ligation, or endometrial ablation?  Yes  No

**By signing below, the prescriber certifies 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 (Required)**

**Date**

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

**Fax This Form to: 1-866-434-5523**

**Mail requests to:** TennCare Pharmacy Program  
 c/o Magellan Health Services  
 1<sup>st</sup> Floor South, 14100 Magellan Plaza  
 Maryland Heights, MO 63043  
 Phone: 1-866-434-5524

**Magellan Health Services will provide a response within 24 hours upon receipt.**