TN Division of TennCare

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

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

Member Information

LAST NAME: **FIRST NAME:**

ID NUMBER: **DATE OF BIRTH:** – –

Prescriber Information

LAST NAME: **FIRST NAME:**

OFFICE ADDRESS:

CITY: **STATE:** **ZIP:**

NPI NUMBER: **DEA NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – –

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 40 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 40 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

Drug Name: _____
Preferred agents: codeine/APAP, Endocet, hydrocodone/APAP, hydrocodone/IBU, hydromorphone, morphine IR, oxycodone, oxycodone/APAP, tramadol
☐ *Non-preferred agent (specify) here: _____

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.
Daily MME Formula: (MME/Unit x # Units for Prescription)/Day's Supply of Prescription

Strength:

Directions:

Quantity Requested:

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 _____

☐ **Total Daily MME patient currently receiving for all opioid agents**:
0_____

*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

Revision Date: 05/01/2018

Magellan HEALTH SERVICES®

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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? ☐ Yes ☐ No (document below with responses)

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? If yes, provide details below: ☐ Yes ☐ No

_____

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? ☐ 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
1st 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.

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