Prior Authorization Form

TennCare Extended Opioid Use Clinical Exceptions: Burn/Corrosion Recovery, Long Term Care, Sickle Cell Disorder

Access this PA form at https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_Exceptions_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 60 MME per day. The first-fill prescription cannot exceed 5-days. Prior authorization is required for all subsequent prescriptions and clinical exceptions. Information and separate PA forms for chronic use exceptions (e.g., 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

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**: ____________

*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

*Continued on next page. Signature **MUST** be submitted on page 3.*

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Revision Date: 09/01/2018

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PATIENT NAME: ☐☐☐☐☐☐☐☐☐☐☐☐ **DATE OF BIRTH:** ☐☐ - ☐☐ - ☐☐☐☐

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): ____________________

For Diagnosis of Sickle Cell Disorder, Burn or Corrosion Recovery or for residents in a Medicaid-certified LTC facility, consideration of coverage of UP TO 45-day quantity of 60 MME per day in any 90-day period requires faxed supporting documentation AND a patient specific clinical action plan.

PLEASE CHECK ALL CATEGORIES THAT APPLY TO THE MEMBER.

Severe Burn or Corrosion Recovery	Sickle Cell Disorder	Medicaid-Certified Long-Term Care Facility
• Is patient moderate-severe pain due to Burn or Corrosion Recovery? ☐ Yes ☐ No Diagnosis (specify and list ICD-10) ____________________ • Has the patient been referred to a Burn Center? ☐ Yes ☐ No • If No, please document why not. ____________________ • FAX supporting documentation and clinical action plan.	• Is patient moderate-severe pain due to Sickle Cell Disorder? ☐ Yes ☐ No Diagnosis (specify and list ICD-10) ____________________ • FAX supporting documentation and clinical action plan.	• Is the patient currently a resident in a Medicaid-certified long-term care facility? ☐ Yes ☐ No • If "YES", please list the name of the facility: ____________________ • If "YES", including supporting documentation and patient specific clinical action plan • If "YES", attach completed PAE form (Pre-Admission Evaluation) and return with this request Diagnosis (specify and list ICD-10) ____________________

2. Have non-pharmacologic therapies been considered? ☐ Yes ☐ No
3. Document most recent date the provider checked the Tennessee Controlled Substance Database for this patient: ___/____/____
4. Has the patient tried non-opioid analgesic treatment? (if "yes", document below with responses) ☐ Yes ☐ No

Non-Opioid Analgesic	Dates	Response

5. Does the patient's pain significantly impair their physical functioning (e.g., ADL's, sleep, work)? ☐ Yes ☐ No
6. Is the patient currently being treated for opioid addiction? ☐ Yes ☐ No
7. **The overutilization of opioid analgesics has been associated with increased risk of opioid used disorder and overdose.**

   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

   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. Has a Patient Controlled Substance Agreement been initiated for this patient? (*If patient less than 18 years of age, may be completed by patient's parent or legal guardian.*) ☐ Yes ☐ No
9. Will this patient be using benzodiazepines and opioids concomitantly? ☐ Yes ☐ No
10. ***IF YES***, is the patient under the care of or been referred to a mental health provider? ☐ Yes ☐ No

*Continued on next page. Signature **MUST** be submitted on page 3.*

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TN Division of TennCare

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PATIENT NAME: ______________________ **DATE OF BIRTH:** __ __ - __ __ - __ __ __ __

11. ***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 12-16. For male patients, go to signature section.

12. **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
13. Is this patient pregnant? ☐ Yes ☐ No
14. Is this patient currently utilizing a form of contraception (e.g. barrier, oral contraceptive, rhythm method)? ☐ Yes ☐ No
15. Does this patient have an intrauterine device (IUD) or implant? ☐ Yes ☐ No
16. 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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