Prior Authorization Form

Morphine Milligram Equivalent (MME)

Access this PA form at https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_MME_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

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:	**Please calculate all short-acting and long-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:	PLEASE LIST all Short and Long-acting opioids patient is currently taking :
DIRECTIONS:	Drug Name; strength_____ Daily MME _____
	Drug Name; strength_____ Daily MME _____
QUANTITY REQUESTED:	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**:_____

***NOTE**: The use of opioid analgesics during pregnancy has been associated with neonatal abstinence syndrome.*

*Continued on next page. Signature **MUST** be submitted on page 2.*

Revision Date: 10/25/17

Prior Authorization Form

Morphine Milligram Equivalent (MME)

Access this PA form at https://tenncare.magellanhealth.com/static/docs/Prior_Authorization_Forms/TennCare_MME_PA_Form.pdf

PATIENT NAME: | **DATE OF BIRTH:** ___ - ___ - ____

Clinical Criteria Documentation *****Do **not** include documentation that is not requested on this form*****

1. Does the patient have chronic intractable pain? ☐ Yes (check all that apply) ☐ No

- ☐ Cancer pain
- ☐ Sickle cell disease
- ☐ HIV/AIDS
- ☐ Hospice patient
- ☐ Vasculitis
- ☐ Lumbago
- ☐ Bone pain
- ☐ Fibromyalgia
- ☐ Lupus
- ☐ Osteoarthritis
- ☐ Degenerative Disc Disease
- ☐ Cervical spine pain (neck pain)
- ☐ Multiple Sclerosis
- ☐ Other: _____

(specify and list ICD-10)

1a. Initial Date of Diagnosis: _____ 1b. Date Narcotics Initiated for Diagnosis: _____

1c. Duration of Therapy: _____

2. Please indicate the specialty of the prescribing physician:

- ☐ Neurology
- ☐ Rheumatology
- ☐ Hematologist
- ☐ Oncology
- ☐ Infectious Disease
- ☐ Board Certified Pain Management
- ☐ Other _____ *(Please list)*

NARCOTIC MONITORING

3. Has a written medical treatment plan with stated objectives consistent with Board of Medical Examiner's rule 0880-2-.14 (website: http://www.tn.gov/sos/rules) been established? ☐ Yes ☐ No
4. Document most recent date the provider checked the Tennessee Controlled Substance Database for this patient: ___/____/____
5. Has a Patient Controlled Substance Agreement (or Pain Management Agreement) been initiated for this patient? ☐ Yes ☐ No

For female patients between the ages of 18 and 45, please complete questions 6–8.

6. **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
7. Is this patient currently utilizing a form of contraception? ☐ Yes ☐ No
8. Has access to contraceptive services been offered to this patient? ☐ Yes ☐ No
9. Has the patient failed to achieve adequate pain control on a dose less than 200 MME per day? ☐ Yes ☐ No

   IF YES, please describe: _____
10. What monitoring strategies have been used for this patient?

- ☐ Pharmacy checks
- ☐ Pill counts
- ☐ Random urine screen
- ☐ Re-evaluation for improved pain relief, physical and psychosocial function
- ☐ Other (please describe): _____

_____ _____

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.