

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

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

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 _____
QUANTITY REQUESTED:	Drug Name; strength _____ Daily MME _____
	Drug Name; strength _____ Daily MME _____
	Drug Name; strength _____ Daily MME _____
	Drug Name; strength _____ Daily MME _____
	<input type="checkbox"/> 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.

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PATIENT NAME:

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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
- | | | | |
|---------------------------------------------|----------------------------------------------|----------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Cancer pain | <input type="checkbox"/> Sickle cell disease | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hospice patient |
| <input type="checkbox"/> Vasculitis | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Bone pain | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Degenerative Disc Disease | <input type="checkbox"/> Cervical spine pain (neck pain) |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> 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:
- | | | | |
|---------------------------------------------|----------------------------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Neurology | <input type="checkbox"/> Rheumatology | <input type="checkbox"/> Hematologist | <input type="checkbox"/> Oncology |
| <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Board Certified Pain Management | <input type="checkbox"/> 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](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?
- | | | |
|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Pharmacy checks | <input type="checkbox"/> Pill counts | <input type="checkbox"/> Random urine screen |
| <input type="checkbox"/> Re-evaluation for improved pain relief, physical and psychosocial function | <input type="checkbox"/> Other (please describe): _____ | |

Prescriber Signature (Required)

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

Date

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.

