

# FLORIDA MEDICAID PRIOR AUTHORIZATION

# **OPIOID AGENTS**

**LENGTH OF APPROVAL: UP TO 3 MONTHS** 

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Full Name:														
Recipient's Medicaid ID#:  Date of Birth (MM/DD/YYYY):														
Prescriber's Full Name:														
Prescriber's NPI:														
Prescriber Phone Number: Prescriber Fax Number:														
☐ Short-Acting Opioid ☐ Long-Acting Opioid ☐ Both  Drug Name:														
Drug Strength:														
Dose:														
Directions:														
Diagnosis:														
Prescriber's Specialty (or consultation with a specialist):														
1. There was a trial and failure of the following medication(s) prior to prescribing short-acting opioids (check all that apply):  Baclofen NSAIDs (oral) Tricyclic antidepressant (e.g., amitriptyline)														
Any requests for post-operative, short-acting opioids cannot exceed a 7-day supply without medical justification.														
<ul> <li>Long-acting opioids are indicated for patients with chronic, moderate to severe pain who require around-the-clock opioid analgesics. Supporting documentation of a minimum two-month trial of short-acting opioid use is required.</li> </ul>														
2. If the request is for a non-preferred agent, trial and failure of preferred agents is required. Medical records documenting trials are also required. List the names of the medications, strength, frequency, length of trials, and rationale for discontinuation.														
3. What is the daily morphine milligram equivalent (MME) of the prescribed medication(s)?														
If patient is treatment-naïve (MME exceeding 90), PA will not be approved.														

(Form continued on next page.)



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Re	ecipient's Full Name																										
١.	Did the prescriber review the <b>Prescribed Drug Monitoring Program</b> prior to prescribing this opioid medication as required by Florida statute?																										
	Y			No																							
	a. If I																										_
	<ul> <li>Submission of a signed patient-prescriber pain management, opioid treatment agreement is required for chronic pain patients</li> <li>When is the next office visit scheduled for the patient with chronic pain? Date:</li> </ul>																										
5.	When	is th	ie ne	xt offi	ce visit	sche	duled	for the	patie	nt wi	th ch	ronic	pain?	Dat	e: _												_
j.	. Has the prescriber ordered and reviewed a urine drug screen (UDS) for new chronic pain patients prior to initiation of opioid therapy? (Submission of a UDS within the past 90 days is required.)  Yes No																										
				_	۸.																						
_																											-
Continuation of Ongoing Therapy																											
١.	Has the prescriber ordered and reviewed a UDS for patients with chronic pain to ensure compliance of opioid therapy? (Submission of a UDS within the past 90 days is required.)																										
	Yes No																										
<u>.</u>	When	When is the next office visit scheduled for the patient with chronic pain? Date:															_										
3.	If requesting an increase in dose or frequency, calculate the new daily morphine milligram equivalent (MME) of the prescribed medication(s) and provide rationale for why this dose is medically necessary.																										
****Clinicians should consider offering naloxone to patients with an increased risk of opioid overdose.****																											
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	Presci	riber	's Sig	gnatur	e:												_ D	ate:									_
						-		ical reco		-	-			ons a	nd ı	ecent	char	t not	es) aı	nd th	ne mo	st rec	ent co	opies	of re	lated	

### Mail or Fax Information to:

Prime Therapeutics State Government Solutions LLC Prior Authorization

P. O. Box 7082

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