Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Morphine Sulfate ER (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Morphine Sulfate ER (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name ***(circle drug)***

morphine sulfate extended release

Other, specify drug ______________________________

Quantity ___________ Frequency ________________ Strength ____________

Route of administration ____________ Expected length of therapy ________________

Patient information

Patient name: ______________________________

Patient ID: ______________________________

Patient Group No.: ______________________________

Patient DOB: ______________________________

Patient phone: ______________________________

Prescribing physician

Physician name: ______________________________

Specialty: ______________________________ NPI number: ______________________________

Physician fax: ______________________________ Physician phone: ______________________________

Physician address: ______________________________ City, state, zip: ______________________________

Diagnosis:______________________________ **ICD Code:**______________________________

Circle the appropriate answer for each question.

1. Is the request for continuation of therapy? [If yes, skip to question 8]	Y	N
2. Is patient 18 years of age or older? [If no, then no further questions.]	Y	N
3. Does the patient have a diagnosis of severe chronic pain (malignant or chronic non-malignant pain) that requires daily, around the clock, long-term opioid treatment as supported by progress notes, discharge notes or health conditions?	Y	N

[If no, then no further questions.]

4. Has the patient tried and failed or has an intolerance or contraindication to the preferred long-acting oral morphine product formulations? Y N

   [If no, then no further questions.]

5. Is the morphine extended release prescribed on a scheduled basis (not “as needed”)? Y N

   [If no, then no further questions.]

6. Is the dose less than or equal to 15 milligrams by mouth every 8 to 12 hours? Y N

   [If yes, then no further questions]

7. Is the patient opioid tolerant as evidenced by recent history (within the past two weeks) of receiving daily opioid analgesics at the following minimum doses FOR AT LEAST ONE WEEK: A) 60 milligrams oral morphine per day, B) 25 microgram per hour of transdermal fentanyl, C) 30 milligrams of oral oxycodone per day, D) 8 milligrams of oral hydromorphone per day, E) 25 milligrams of oral oxymorphone per day Y N

   [No further questions]

8. Does the patient meet ALL of the following: A) continues to meet all of the initial review criteria, B) compliant with medication refills, C) no medication fills for any other long acting opioid, D) no history of behavior indicative of abuse including requests for early refills? Y N

Comments:

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I affirm that the information given on this form is true and accurate as of this date.

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Prescriber (Or Authorized) Signature **Date**