



Fax completed prior authorization request form to 855-799-2551 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

Aetna Better Health®

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/michigan/providers/medicaid/pharmacy

Opioids – Short-Acting and Intermediate-Acting - Michigan PDL Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information				
Member Name (first & last):	Date of Birth:	Gender:		Height:
		<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Member ID:	City:	State:		Weight:
Prescribing Provider Information				
Provider Name (first & last):	Specialty:	NPI#	DEA#	
Office Address:	City:	State:	Zip Code:	
Office Contact:	Office Phone		Office Fax:	
Dispensing Pharmacy Information				
Pharmacy Name:	Pharmacy Phone:		Pharmacy Fax:	
Requested Medication Information				
Specify drug:				
Are there any contraindications to formulary medications? (if yes, please specify):				
	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy request
Directions for Use:		Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:	
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No		Diagnosis:	ICD-10 Code:	
What medication(s) have been tried and failed for this diagnosis? Please specify:				
Turn-Around Time for Review				
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> Urgent – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.		
Signature: _____				
Clinical Information				
<input type="checkbox"/> Short and Intermediate Acting Opioids				
Has the member experienced a therapeutic failure with a ONE WEEK trial of TWO preferred medications?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the member have any of the following to the preferred medication(s): check all that apply		<input type="checkbox"/> Allergy <input type="checkbox"/> Contraindication or drug interactions <input type="checkbox"/> History of unacceptable side effects		
Is this request for an ORAL fentanyl product (i.e., fentanyl citrate buccal)? If YES , please answer questions to the right. <input type="checkbox"/> Yes	Is the requested drug being prescribed for the management of breakthrough cancer pain for a member established on immediate release and long-acting opioid therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is this request for controlled substances under the name and ID of the prescribing physician?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is the requested drug being prescribed by a physician who is experienced in the use of Schedule II opioids?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

<input type="checkbox"/> No	Has the current dosage regimen of the long acting and regularly prescribed immediate release opioids been maximally optimized?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Will there be concomitant use of other inducers or inhibitors of cytochrome P450?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is this request for Roxibond® (Oxycodone) tablets? If YES , please answer the question to the right. <input type="checkbox"/> Yes <input type="checkbox"/> No		Is an abuse deterrent formulation needed?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this request for tramadol (Qdolo) Oral Solution? If YES , please answer the question to the right. <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the member have difficulty swallowing tablets?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this request for Seglantis (celecoxib/tramadol)? If YES , please the answer question to the right. <input type="checkbox"/> Yes <input type="checkbox"/> No		Does the prescriber attest that medication will not be used for postoperative management in children younger than 18 years of age following tonsillectomy and/or adenoidectomy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the request for a codeine or tramadol containing product?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is the member 12 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Initial High Morphine Milligram Equivalents (MME)				
Does the member have any of the exceptions listed to the right? If YES , no further questions. <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the member have documented "current" cancer-related pain?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does the member have pain related to sickle cell disease?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Is the member in hospice or palliative care?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Does the member reside in a long-term care facility that is exempt from reporting to or checking the State Prescription Monitoring Program (i.e., MAPS)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Additional High Morphine Milligram Equivalents (MME)				
Prescriber attests to all of the following? <input type="checkbox"/> Yes <input type="checkbox"/> No	Risk assessment has been performed?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Pain Medication Agreement with informed consent has been reviewed with, completed, and signed by the member?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	MAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Concurrently prescribed drugs have been reviewed and that based on prescriber's assessment the drugs and doses are safe for the member?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Concurrently prescribed drugs have been reconciled and reviewed for safety		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Non-opioid medications have been recommended and/or utilized?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss, have been recommended and/or utilized?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	A toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Results from toxicology screen showed expected results?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Member has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Member has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g., benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Has documentation been submitted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Current documentation provided outlining pain related to history and physical(s) including clinical justification supporting need for exceeding high MME?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Recent non-opioid medications utilized for pain management or rationale these cannot be used?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Documentation includes lists of all current opioid medications (long and short-acting) and when the regimen was initiated?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Has the member's current daily Morphine Milligram Equivalent been calculated?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Pregnant patients on opioids are considered high-risk patients and need to be followed by an OB/GYN. If member is pregnant has the name of the OB/GYN been submitted with request?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal				
Has documentation been submitted showing the member continues to meet high MME criteria?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has documentation of taper plan or rationale why taper is not appropriate been submitted ?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 855-300-5528 to check the status of a request.