AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

SHORT AND LONG-ACTING OPIOIDS

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

This request is for: ☐ **Short-Acting Opioid** ☐ **Long-Acting Opioid** ☐ **BOTH (check all that apply)**

Service Authorization is required for:

1. All Long-Acting Opioids
2. Any Short-Acting Opioid prescribed for >7 days or two 7-day supplies in a 60-day period. The Virginia BOM Regulations limit the treatment of acute pain with opioids to 7 days.
3. Any cumulative opioid prescription exceeding 90 morphine milligram equivalents (MME) per day. Quantity limits apply to each drug.

Long-Acting Opioids (LAOs): LAOs are indicated for members with chronic, moderate to severe pain who require daily, around-the-clock opioid treatment and require a PA. Consider non-pharmacologic and non-opioid pain treatments prior to treatment with opioids. Members should be considered for buprenorphine analgesic treatment with either topical patch since this product has a ceiling effect with less risk of respiratory depression than other opioids.

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

Preferred Long-Acting Opioids (Sch III-VI)	Butrans® Transdermal Patch	
Preferred Long-Acting Opioids (Sch II)	fentanyl 12, 25, 50, 75, and 100 mcg patches morphine sulfate ER tab	
Preferred Short-Acting Opioids	codeine/APAP hydrocodone/APAP hydrocodone/ibuprofen hydromorphone morphine IR	oxycodone IR oxycodone/APAP tramadol HCl 50 mg tramadol HCl/APAP

Drug 1	Drug 2
Drug Name/Form:	**Drug Name/Form:**
Strength:	**Strength:**
Dosing Frequency:	**Dosing Frequency:**
Length of Therapy:	**Length of Therapy:**
Quantity per Day:	**Quantity per Day:**

Alternative Therapy to Schedule II Opioids. Based on the Virginia Board of Medicine's Opioid Prescribing Regulations, Opioids are not recommended as first line treatment for acute or chronic pain. For additional information, please see VA Board of Medicine Regulations: http://www.dhp.virginia.gov/medicine/

Preferred Pain Relievers available without PA include NSAIDS topical and oral, SNRIs, Tricyclic Antidepressants, Gabapentin, Baclofen, Capsaicin topical cream 0.025%, Lidocaine 5% Patch and Pregabalin (Lyrica®). Consider alternative therapies to Schedule II opioid drugs due to their high potential for abuse and misuse.

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

TREATMENT INFORMATION

PA Criteria Align with the Virginia Board of Medicine's Regulations Governing Prescribing of Opioids and Buprenorphine: http://www.dhp.virginia.gov/medicine/

Length of authorization: 3 months based on the following diagnosis (please check all that apply):

- ☐ HIV/AIDS
- ☐ Chronic back pain
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Diabetic neuropathy
- ☐ Postherpetic neuralgia
- ☐ Other:_____

Length of authorization: 6 months based on the following diagnosis (please check all that apply):

- ☐ Cancer pain
- ☐ Sickle cell disease
- ☐ Palliative care
- ☐ End-of-Life care
- ☐ Hospice patient

4. **Does the prescriber attest that the member has pain associated with cancer, palliative care (treatment of symptoms associated with life-limiting illnesses), sickle cell disease, or hospice care? (if Yes, please sign and submit, no further information required unless a non-preferred is prescribed. See question 8 if a non-formulary drug is prescribed.)**
   ☐ **Yes** ☐ **No**

5. **Is the member in remission from cancer and is the prescriber safely weaning the member off opioids with a tapering plan? (if Yes, please sign and submit, no further information required unless a non-preferred drug is prescribed. See question 8 if a non-formulary drug is prescribed.)**
   ☐ **Yes** ☐ **No**

6. Is the member in a long-term care facility? (**if Yes, please sign and submit, no further information required** unless a non-preferred/non-formulary drug is prescribed. See question 8 if non-preferred drug is prescribed.)
   ☐ Yes ☐ No

7. Has the member tried and failed any of the following therapies covered without PA *(select all that apply)*?
   - ☐ Baclofen
   - ☐ Capsaicin gel
   - ☐ Duloxetine
   - ☐ Gabapentin
   - ☐ Lidocaine 5% patch
   - ☐ NSAIDs (oral)
   - ☐ Physical therapy
   - ☐ Tricyclic antidepressant (e.g., nortriptyline)
   - ☐ Cognitive behavioral therapy (CBT)
   - ☐ Other: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

TREATMENT INFORMATION (*CONTINUED*)

8. If requesting a non-preferred product (e.g., Avinza®, Kadian®, Embeda®), has the member tried and failed an adequate trial of 2 different preferred products?

   ☐ Yes ☐ No

   If **Yes**, please list drug name, length of trial, and reason for discontinuation.

   _____

9. What is the member's Active Daily MME from the PMP (https://virginia.pmpaware.net/login)?

   MME: _____

   a. If member's Active Daily MME is greater than or equal to 90, does the prescriber attest that he or she will be managing the member's opioid therapy long term, has reviewed the Virginia BOM Regulations for Opioid Prescribing, has prescribed naloxone, and acknowledges the warnings associated with high dose opioid therapy including fatal overdose, and that therapy is medically necessary for this member?

      ☐ Yes ☐ No ☐ N/A

10. If a benzodiazepine prescription has been filled in past 30 days, does the prescriber attest that he or she has counseled the member on the FDA black box warning on the dangers of prescribing opioids and benzodiazepines including fatal overdose, has documented that the therapy is medically necessary, and has recorded a tapering plan to achieve the lowest possible effective doses of both opioids and benzodiazepines per the Board of Medicine Opioid Prescribing Regulations?

    ☐ Yes ☐ No ☐ N/A

11. Has naloxone been prescribed for members with risk factors of overdose? Risk factors for overdose include substance use disorder, doses in excess of 50 MME/day, antihistamines, antipsychotics, benzodiazepines, gabapentin, pregabalin, tricyclic antidepressants, or the "Z" drugs (zopiclone, zolpidem, or zaleplon).

    ☐ Yes ☐ No

12. If the member is of childbearing potential and between 18 and 45 years old, has the prescriber discussed risk of neonatal abstinence syndrome and provided counseling on contraceptive options?

    ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process.
Submission of documentation does NOT guarantee coverage.