MOLINA HEALTHCARE
Service Authorization (SA) Form
SHORT AND LONG-ACTING OPIOIDS

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

MEMBER INFORMATION

Last name:

First name:

Medicaid ID number:

Date of birth: ____ – ____ – ____

Gender: ☐ **Male** ☐ **Female**

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 more than 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 service authorization (SA) form. Consider non-pharmacologic and non-opioid pain treatments prior to treatment with opioids. Members should be considered for buprenorphine analgesic treatment with topical patch since this product has a ceiling effect with less risk of respiratory depression than other opioids.

www.virginiamedicaidpharmacyservices.com/provider/external/medicaid/vamps/doc/en-us/VAMPS_Short_and_Long_Acting_Opioid_Daily_Dose_Limit.pdf

Revised: 06/2023 | Effective: 07/15/22

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 & 100 mcg patches morphine sulfate ER tab
Preferred short-acting opioids	codeine/APAP hydrocodone/APAP P hydrocodone/ibuprofen mg hydromorphone HCl/APAP morphine IR oxycodone IR oxycodone/APA tramadol HCl 50 tramadol

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 SA 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. A complete list of covered drugs can be found at: wwwvirginiamedicaidpharmacyservices.com/documents/VAmed-PDL-List-Criteria.

(Form continued on next page.)

Member's last name: **Member's frst name:**

TREATMENT INFORMATION

SA criteria align with the Virginia Board of Medicine's Regulations Governing Prescribing of Opioids and Buprenorphine: 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

1. Does prescriber attest that the member has intractable pain associated with active cancer, palliative care (treatment of symptoms associated with life limiting illnesses), or hospice care? (IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless a non-preferred/non-formulary drug is prescribed. See Question 5 if a non-preferred drug is prescribed.)

   ☐ Yes ☐ No

2. Is member in remission from cancer and prescriber is safely weaning member off opioids with a tapering plan? (IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless a non-preferred/ non-formulary drug is prescribed. See Question 5 if a non-preferred drug is prescribed.)

   ☐ Yes ☐ No

3. Is 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 5 if a non-preferred drug is prescribed.)

   ☐ Yes ☐ No

4. Please indicate if the member has tried and failed any of the following therapies covered without SA *(select all that apply)*:

- ☐ Baclofen
- ☐ Duloxetine
- ☐ Lidocaine 5% patch
- ☐ Physical therapy
- ☐ Cognitive behavioral therapy (CBT)
- ☐ Capsaicin gel
- ☐ Gabapentin
- ☐ NSAIDs (oral)
- ☐ Tricyclic antidepressant (e.g., nortriptyline)
- ☐ Other: _____

(Form continued on next page.)

Member's last name: **Member's first name:**

5. 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 names, length of trials, and reasons for discontinuation.

   _____

6. Provide the member's active daily MME from the PMP (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/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

7. If benzodiazepine was filled in past 30 days, does the prescriber attest that he/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

8. 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

9. If member is an 18–45-year-old female, 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 SA process.

Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be **faxed to (844) 278-5731**, or you may call **(800) 424-4518. (TTY: 711)**.