Opioid Analgesic Treatment Worksheet (Consolidated)

☐ **Aetna Better Health of Louisiana**
Fax: 1-844-699-2889
For questions only, please call 1-855-242-0802.
www.aetnabetterhealth.com/louisiana/providers/pharmacy

☐ **Healthy Blue**
Fax: 1-844-864-7865
For questions, please call 1-844-521-6942
https://providers.healthybluela.com

☐ **AmeriHealth Caritas Louisiana**
Fax: 1-855-452-9131
For questions, please call 1-800-684-5502.
www.amerihealthcaritasla.com/pharmacy/index.aspx

☐ **Fee for Service (FFS) Louisiana Legacy Medicaid**
Fax: 1-866-797-2329
For questions, please call 1-866-730-4357.
www.lamedicaid.com

☐ **LA Healthcare Connections**
Fax: 1-866-399-0929
For questions, please call 1-888-929-3790.
www.louisianahealthconnect.com/for-members/pharmacy-services/

☐ **UnitedHealthcare**
Fax: 1-866-940-7328
For questions, please call 1-800-310-6826.
www.uhccommunityplan.com/health-professionals/la/pharmacy.html

Please fax the completed form to the appropriate plan using the designated fax number provided above.

Recipient Name:	FFS / MCO ID #:	Recipient DOB:	Medication Allergies:
Resident of long-term care facility: Yes / No If yes, name and phone number:		Recipient Weight (kg):	Recipient Height (ft/in):
Prescriber Name:	Prescriber Specialty:	Medicaid Provider ID # or NPI#:	
Prescriber Address:	Call-Back Phone#:		
Office Fax#:	Office Contact:	EPSDT Support Coordinator (Name/Address): *(optional)*	

DRUG INFORMATION (one drug per request)

Drug Name / Dosage Form:_____Strength:_____Quantity:_____

Requested medication is short-acting / long-acting. (CIRCLE ONE) Directions:_____

Diagnoses for which the opioid is prescribed (include primary and secondary diagnoses applicable to this request, ICD code and description):
Diagnosis:_____ Diagnosis:_____
Date of Diagnosis:_____ Date of Diagnosis:_____

This medication is being used for: _____acute condition _____chronic condition (check one only)

Is this medication being used for moderate to severe neuropathic pain or fibromyalgia? _____Yes _____No

Is this medication being used for postoperative pain? _____Yes _____No If yes, date of surgery_____

This medication is a PREFERRED / NON-PREFERRED Agent. (CIRCLE ONE)

If PREFERRED, CONTINUE to page 2.

If request is for a non-preferred agent, recipient must have had treatment failure with at least two (2) preferred agents.

Previously Tried Preferred Agents*	Reason for Discontinuation

**Refer to the appropriate MCO / FFS website at top of page for a list of preferred agents.*

OR if preferred agents have **not** been previously tried, provide explanation: _____

_____

Does individual require an abuse deterrent agent based upon a history of substance abuse disorder OR individual's family member or household resident has active substance abuse disorder or a history of substance abuse disorder? _____Yes _____No

Does individual require Butrans (buprenorphine transdermal patch) or Belbuca (buprenorphine buccal film) due to concern for abuse or dependence with pure opioid agents? _____Yes _____No

Is this request for medication prescribed for treatment of pain related to cancer, palliative care, hospice, or end-of-life care?

_____Yes _____No
If NO, proceed to next section.
If YES, STOP HERE, sign below and fax form to the appropriate plan above.

Prescriber's signature:_____
(For FFS and Amerihealth Caritas, appropriate diagnosis code must be entered at POS.)

DOES QUANTITY REQUESTED EXCEED THE MAXIMUM QUANTITY LIMIT? YES / NO (CIRCLE ONE)

DOES DAILY MED EXCEED THE MAXIMUM MED ALLOWED PER DAY? YES / NO (CIRCLE ONE)

If answer is YES to either of these questions, continue to next section and complete the form in its entirety.

Request is for: _____Initiation of therapy _____Continuation of Therapy If continuation, is dose currently being tapered? _____Yes _____No

If no, explain:_____

Recipient's current *CUMULATIVE* MED PER DAY:_____ (include MED of medication being requested)

Note: The Louisiana Prescription Monitoring Program (PMP) provides the cumulative MED for all of the recipient's controlled medications. Information is current through the previous day (the day before the PMP is accessed).

For **quantity limit override OR MED override**, explain in detail the need for requested quantity/MED:

_____

_____

_____

List **treatments that have been tried or are currently being given** for this condition, both pharmacological and non-pharmacological:

Pharmacological Treatments (both opioid and nonopioid)			
Drug / Strength	**Directions**	**Start Date / End Date (or Current)**	**Reason for Discontinuation (if applicable)**

Non-pharmacological Treatments	
Treatment	**Start Date / End Date (or Current)**

PRESCRIBER ATTESTATION

Please indicate YES/True or NO/False for each of the following attestations. Explanation is required for each 'No/False' answer in order for the request to be considered for approval. For short-acting opioids, complete A – G; for long-acting opioids, complete A – L.

	YES (True)	NO (False)	THE PRESCRIBER ATTESTS TO THE FOLLOWING:
SHORT AND LONG-ACTING OPIOIDS			A. A complete **assessment** for pain and function was performed for this patient and **documentation is attached**.
			B. The patient has been **screened for substance abuse / opioid dependence** and **documentation is attached**. *(Not required for recipients in long-term care facility.)*
			C. The **PMP** will be accessed **each** time a controlled prescription is written for this patient.
			D. A **treatment plan** which includes current and previous goals of therapy for both pain and function has been developed for this patient.
			E. **Criteria** for failure of the opioid trial and for stopping or continuing the opioid has been established and explained to the patient.
			F. **Benefits and potential harms** of opioid use have been discussed with this patient. In addition, if the patient has concurrent comorbidities or is taking medications that could potentially cause drug-drug interactions, an assessment of increased risk for respiratory depression has been completed and discussed with the patient. The risk of combining opioids with other central nervous system depressants, such as benzodiazepines, alcohol, or illicit drugs such as heroin, has also been specifically addressed. The level of risk for opioid abuse/overdose with the dose/duration prescribed to the patient has also been discussed.
			G. An **Opioid Treatment Agreement** signed by both the patient and prescriber is on file. *(Not required for recipients in long-term care facility.)*
LONG-ACTING OPIOIDS			H. The patient requires continuous **around the clock** analgesic therapy for which alternative treatment options have been inadequate or have not been tolerated.
			I. Patient previously utilized at least two weeks of short-acting opioids for this condition. Please enter drug(s), dose, duration and date of trial in *Pharmacological Treatment Section* on page 1.
			J. Medication has **not** been prescribed to treat acute pain, mild pain, or pain that is not expected to persist for an extended period of time.
			K. Medication has **not** been prescribed for use as an as-needed (PRN) analgesic.
			L. Prescribing information for requested product has been **thoroughly reviewed** by prescriber.

*IF NO FOR **ANY** OF THE ABOVE (A-L), PLEASE EXPLAIN:*

Opioid overdose reversal medications are a covered benefit. Prior authorization is not required for some products. CDC guidelines recommend offering naloxone to patients at increased risk of overdose, defined as: history of overdose or substance use disorder, doses ≥ 50 MED /day, or concurrent use with benzodiazepines. ***Please refer to the appropriate MCO / FFS website (top of page 1) for a list of preferred agents.***

I certify that the benefits of opioid treatment for this patient outweigh the risks of treatment and that the information provided herein is true and accurate to the best of my knowledge and may be subject to a routine audit requesting the medical information necessary to verify the accuracy of the information provided.

Please note: An approval is not a guarantee of payment. All edits will apply when medication is processed at point-of-sale (POS). Payment on a claim will only be made when the claim is billed correctly and all conditions for payment are met.

Prescriber's Signature: _____Date: _____