Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Fax 800-913-2229

Amerigroup
PA Pharmacy Phone 855-201-7170
PA Pharmacy Fax 800-601-4829

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929

UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328

Prior Authorization for Opioid Products Indicated for Pain Management

Long Acting*	Short Acting*
Buprenorphine (Butrans, Belbuca)	Benzhydrocodone
Fentanyl transdermal (Duragesic)	Codeine
Hydrocodone extended-release (Zohydro ER, Hysingla ER, Vantrela ER)	Dihydrocodeine
Hydromorphone extended-release (Exalgo)	Fentanyl
Methadone	Hydrocodone
Morphine controlled-release/extended-release (Kadian ER, Avinza, MS Contin, Oramorph, Arymo ER)	Hydromorphone
Morphine/Naltrexone (Embeda)	Levorphanol Tartrate
Oxycodone extended-release (OxyContin)	Meperidine
Oxycodone extended-release (Xtampza ER)	Morphine
Oxycodone/Naloxone (Targiniq ER)	Oxycodone
Oxycodone/Naltrexone (Troxyca ER)	Oxymorphone
Oxymorphone extended-release (generic non-crush resistant)	Pentazocine/Naloxone
Oxymorphone extended-release (Opana ER-crush resistant)	Tapentadol
Tapentadol extended-release (Nucynta ER)	Tramadol
Tramadol extended-release (Ultram ER, Ryzolt)	

***Includes brand and generic versions of the listed products unless otherwise noted (all salt forms, single and combination products, and all brand and generic formulations).**

Beneficiary Information

Name:_____

Medicaid ID #:_____ Date of Birth: _____ Gender: _____

Billing Provider Information (Pharmacy, Physician or Facility)

Name:_____ Medicaid ID #:_____

NPI #:_____ Phone #:_____ Fax #:_____

Prescriber Information

Name:_____ Medicaid ID #:_____

NPI #:_____ Phone #:_____ Fax #:_____

REQUESTED DRUG

Drug Name: _____ Dosage Strength: _____Quantity: _____ Day Supply: _____

Length of Therapy: _____ Diagnosis:_____ ICD 10 Code: _____

- **If request is for methadone, patient must have a diagnosis of terminal cancer pain.**
- **If request is for fentanyl patches, patient must have a diagnosis of cancer/palliative care related pain.**
- **If request is for Transmucosal Immediate Release Fentanyl (TIRF) product, patient must have a diagnosis of cancer AND prescriber must attest that they are enrolled in TIRF REMS.**

Please check the following boxes: Prescriber is enrolled in TIRF REMS Program ☐ **YES** ☐ **NO**

Please complete questions 1 – 6:

1) Is patient being treated for pain related to active cancer diagnosis, sickle cell disease, or receiving hospice or palliative care?

☐ **YES** Please Indicate: ☐ **Cancer** ☐ **Sickle Cell Disease** ☐ **Hospice/Palliative Care**
If **YES**, **form is complete**

☐ **NO** If NO, complete questions 2 through 5

2) Has patient received an opioid prescription for **< 90 days** in a look back period of 4 months?

☐ **YES** If **YES**
↳ For **initial request**, complete **section A**
↳ For **renewal of a previous approval**, complete **Section B**

☐ **NO**

3) Has patient received an opioid prescription for **≥ 90 days** in a look back period of 4 months?

☐ **YES** If **YES**
↳ For **initial request**, complete **section A & C**
↳ For **renewal of a previous approval**, complete **Section C & D**

☐ **NO**

4) Does dose exceed 90 MME/day?*****

☐ **YES** If **YES,** complete **Section E**
☐ **NO**

MME Calculator http://www.agencymeddirectors.wa.gov/calculator/dosecalculator.htm
CMS MME Conversion Guide https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-Aug-2017.pdf

5) Is the request for a long-acting opioid?*****

☐ **YES** If **YES,** complete **Section F**
☐ **NO**

***Doses exceeding 90 MME/day and long acting opioid requests will only be approved for patients who have received opioid prescriptions for ≥90 days in a look back period of 4 months.**

6) Is the request for a non-preferred medication?

☐ **YES** If **YES,** complete **Section G**
☐ **NO**

Kansas Medicaid Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf

***PLEASE COMPLETE ONE OR MORE OF THE FOLLOWING SECTIONS BASED ON THE PA CRITERIA FOR THE MEDICATION BEING REQUESTED.**

SECTION A: INITIAL PA (Prescriber must attest to ALL of the following for PA approval)		
Y	**N**	
		Prescriber has KMAP ID (required for opioid prescription approval)
		Patient has attempted or is contraindicated to treatment with at least 2 non-opioid ancillary treatments (e.g. NSAIDS, antidepressants, acetaminophen) in the last 90 days. Trial 1 Drug Name:_____ Date_____ Outcome_____ Trial 2 Drug Name:_____ Date_____ Outcome_____ List Contraindication or Intolerance (if any): _____
		Non-pharmacological treatment has been tried and/or is currently being used (e.g. exercise, cognitive behavior therapy, or interventional treatment).
		Prescriber has reviewed prescriptions for controlled substances in the Prescription Drug Monitoring Program (PDMP)/K-TRACS.
		Patient has been screened for substance abuse/opioid dependence.
		If patient is concurrently on a CNS depressant (e.g. benzodiazepines), prescriber has reviewed and will address the increased risk of respiratory depression with the patient.
		Patient has been screened for depression or other mental illnesses.
		If patient is positive for depression, patient is receiving either pharmacological or nonpharmacological treatment.
		Treatment duration and goals are defined with the patient and within the medical record.

SECTION B: Patients with <90 opioid prescription in past 4 months - renewal (must meet ALL following)		
Y	**N**	
		Dose/frequency taper has been attempted.
		Reason for not tapering dose/frequency is documented in medical record.

Taper Outcome: _____

Rational for not tapering: _____

SECTION C: Patients with ≥90 opioid prescription in past 4 months (must meet ALL following)		
Y	**N**	
		Patient has a pain management/opioid agreement with the prescriber.
		Patient has/will have random urine drug screens as part of their on-going therapy with opioids.
		Rationale for not tapering and discontinuing opioid.*****

*****Prescriber's rationale supporting inability to taper or discontinue opioid therapy: _____

_____

_____

SECTION D: Patients with ≥90 opioid prescription in past 4 months - renewal (must meet ALL following)		
Y	**N**	
		All narcotic analgesics are written by a single KMAP-enrolled prescriber or practice.
		Prescriber has reviewed prescriptions for controlled substances in the Prescription Drug Monitoring Program (PDMP)/K-TRACS.
		Patient will not be maintained on more than one long-acting and one short-acting opioid analgesic concurrently.
		Documentation of treatment duration and treatment goals.*

*Treatment duration and goals: _____

_____

SECTION E: DOSE EXCEEDS 90 MME/DAY (must meet one of the following)		
Y	**N**	
		Dose reduction has occurred since previous approval. Previous Dose: _____ New Dose: _____
		There is documentation of an attempted unsuccessful dose taper within the past 6 months. Taper Date: _____ Taper Outcome: _____

SECTION F: LONG-ACTING OPIOID (must meet ALL of the following)		
Y	**N**	
		Patient has received a short-acting opioid for greater than 30 days in the last 60 days.
		Patient has a documented history of failure, contraindication or intolerance to a trial of at least two preferred short-acting opioids. Trial 1 Drug Name:_____ Date_____ Outcome_____ Trial 2 Drug Name:_____ Date_____ Outcome_____ List Contraindication or Intolerance (if any): _____ _____
		Tried and failed at least two preferred long-acting opioids before the use of a non-preferred unless there is intolerance or contraindications. Trial 1 Drug Name:_____ Date_____ Outcome_____ Trial 2 Drug Name:_____ Date_____ Outcome_____ List Contraindication or Intolerance (if any): _____ _____

SECTION G: NON-PREFERRED MEDICATION

(ACCESS THE PREFERRED DRUG LIST (PDL) AT: http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf**)**

Please check the appropriate box and provide the required information to receive the requested non-preferred drug.

Y	N	INTOLERANCE/ ALLERGY	
			If there is one preferred agent in the preferred category, has the patient tried and failed the one preferred agent in the last 180 days (unless medical intolerance/allergy)? Trial – Drug Name: _____ Date of Trial: _____ List medical intolerance/allergy (if any): _____ _____
			If there are two or more preferred agents in the preferred category, has the patient tried and failed two preferred agents in the last 180 days (unless medical intolerance/allergy)? Trial – Drug Name: _____ Date of Trial: _____ Trial – Drug Name: _____ Date of Trial: _____ List medical intolerance/allergy (if any): _____ _____
			An appropriate formulation or indication is not available as a preferred drug. Please specify which formulation or indication is needed and information supporting the need: _____ _____ _____

Prescriber's Signature:_____**Date:**_____

This form will be returned unprocessed if it is not completed in its entirety.