Updated: 10/2021
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Request for Prior Authorization for Opioid Analgesics
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

Requests for opioid analgesics may be subject to prior authorization and will be screened for medical necessity and appropriateness using the prior authorization criteria listed below.

All requests for opioids will reject for members with an active claim for opioid dependence treatment (e.g. buprenorphine/naloxone, naltrexone) and will be subject to individual review and approval.

Members with documented active cancer, hospice/palliative care, or sickle cell diagnoses are exempt from prior authorization requirements.

Section I. Short-acting opioid Prior Authorization Criteria

- Coverage may be provided for a **short-acting opioid** when the duration of therapy threshold is exceeded and the following criteria is met:
  - Duration of therapy thresholds:
    - Prior authorization is required for adults (≥ 21 years of age) when more than a 5 day supply is prescribed (whether obtained from a single prescription or multiple prescriptions) in a 30 day period.
    - Prior authorization is required for children (< 21 years of age) when more than a 3 day supply is prescribed (whether obtained from a single prescription or multiple prescriptions) in a 30 day period.

Initial Criteria

i. A pain assessment (type, cause, duration, severity of pain, etc.) is provided.
ii. A signed provider-patient pain management contract is submitted
iii. Documentation the member has tried and failed or has an intolerance or contraindication to non-pharmacologic therapies (e.g. behavioral, cognitive, physical therapies, and in situations where covered, acupuncture and/or yoga).
iv. Documentation the member has tried and failed or has an intolerance or contraindication to non-opioid analgesics (e.g. acetaminophen, NSAID, antidepressant, anticonvulsant).
v. Documentation the short-acting opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
vi. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Delaware Prescription Monitoring Program (DPMP) database for the member's controlled substance prescription history.
i. Provider has evaluated the member for risk factors for opioid-related harm.

1. If the member is identified at high risk for opioid related harm, the provider has educated the member on being a candidate for carrying naloxone.

vii. Documentation the member, or parent/guardian, has been educated on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction.
viii. Member is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined medically necessary.
ix. A recent UDS has been completed and results are consistent with prescribed controlled substances. If the UDS is not consistent, provider must state the results and resolution.
x. Authorization length: up to three (3) months

Reauthorization criteria

i. Documentation is submitted that shows an improvement in pain control and level of functioning. Rationale is provided for continued use of opioid therapy or a plan for taper/discontinuation.
ii. Documentation the short-acting opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
iii. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Delaware Prescription Monitoring Program (DPMP) database for the member's controlled substance prescription history.
iv. Provider has evaluated the member for risk factors for opioid-related harm.
    1. If the member is identified at high risk for opioid related harm, the provider has educated the member on being a candidate for carrying naloxone.
v. Member is being monitored by the prescriber for adverse events and warning signs for serious problems, such as overdose and opioid use disorder.
vi. Member is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined medically necessary.
vii. A UDS has been completed every 6 months and results are consistent with prescribed controlled substances. If the UDS is not consistent, provider must state the results and resolution.
viii. Authorization length: up to six (6) months
    1. In situations when the request is deemed not medically necessary and the member is currently on chronic opioids and/or benzodiazepines, up to a three (3) month authorization will be granted to allow for tapering of medication(s).
    2. For members who require longer than a 3 month taper, the provider must submit either a tapering plan or discontinuation plan to support the extended length of time.

Section II. Long-acting opioid Prior Authorization Criteria

All long-acting opioids require prior authorization and will be screened for medical necessity and appropriateness using the prior authorization criteria listed below.

- Coverage may be provided for a **long-acting opioid** when the following criteria is met:

Initial Criteria

i. A pain assessment (type, cause, duration, severity of pain, etc.) is provided.
ii. A signed provider-patient pain management contract is submitted
iii. Documentation the member has tried and failed or has an intolerance or contraindication to non-pharmacologic therapies (e.g. behavioral, cognitive, physical therapies, and in situations where covered, acupuncture and/or yoga).
iv. Documentation the member has tried and failed or has an intolerance or contraindication to non-opioid analgesics (e.g. acetaminophen, NSAID, antidepressant, anticonvulsant).
v. Documentation the long-acting opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
vi. Documentation the member has had a trial of at least one short-acting opioid.
vii. The long-acting opioid must be prescribed for ongoing continuous therapy. Long-acting opioids are not intended to be used on an as-needed (prn) basis.
viii. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Delaware Prescription Monitoring Program (DPMP) database for the member's controlled substance prescription history.
ix. Provider has evaluated the member for risk factors for opioid-related harm.
    1. If the member is identified at high risk for opioid related harm, the provider has educated the member on being a candidate for carrying naloxone.
x. Documentation the member, or parent/guardian, has been educated on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction.
xi. Member is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined medically necessary.
xii. A recent UDS has been completed and results are consistent with prescribed controlled substances. If the UDS is not consistent, provider must state the results and resolution.
xiii. Authorization length: up to three (3) months

Reauthorization criteria

i. Documentation is submitted that shows an improvement in pain control and level of functioning. Rationale is provided for continued use of opioid therapy or a plan for taper/discontinuation.
ii. Documentation the long-acting opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
iii. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Delaware Prescription Monitoring Program (DPMP) database for the member's controlled substance prescription history.
iv. Provider has evaluated the member for risk factors for opioid-related harm.
    1. If the member is identified at high risk for opioid related harm, the provider has educated the member on being a candidate for carrying naloxone.
v. Member is being monitored by the prescriber for adverse events and warning signs for serious problems, such as overdose and opioid use disorder.

vi. Member is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined medically necessary.
vii. A UDS has been completed every 6 months and results are consistent with prescribed controlled substances. If the UDS is not consistent, provider must state the results and resolution.
viii. Authorization length: up to six (6) months
    1. In situations when the request is deemed not medically necessary and the member is currently on chronic opioids and/or benzodiazepines, up to a three (3) month authorization will be granted to allow for tapering of medication(s).
    2. For members who require longer than a 3 month taper, the provider must submit either a tapering plan or discontinuation plan to support the extended length of time.

Section III. Quantity Limit Prior Authorization Criteria

Short and/or long-acting opioid analgesics will require prior authorization when exceeding a quantity limit and/or meeting or exceeding the cumulative daily dose threshold of 90 MME and will be screened for medical necessity and appropriateness using the prior authorization criteria listed below.

- Coverage may be provided for quantities exceeding the threshold or quantity limit when the following criteria is met (in addition to the above prior authorization criteria, if applicable):
    i. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Delaware Prescription Monitoring Program (DPMP) database for the member's controlled substance prescription history.
    ii. A signed provider-patient pain management contract is submitted
    iii. A treatment plan, including clinical rationale to support medical necessity for the high dose, is provided.
    iv. For chronic pain diagnoses: If requesting high doses of short-acting opioids in the absence of a long-acting opioid, clinical rationale is provided for not utilizing a long-acting opioid.
    v. For members meeting or exceeding 90 MME/day, the provider has educated the member on being a candidate for carrying naloxone.
    vi. If requested dosing frequency exceeds the maximum FDA-approved dosing frequency, clinical rationale is provided to support medical necessity.
    vii. Authorization length: up to six (6) months
        1. In situations when the request is deemed not medically necessary and the member is currently on chronic opioids and/or benzodiazepines, up to a three (3) month authorization will be granted to allow for tapering of medication(s).
        2. For members who require longer than a 3 month taper, the provider must submit either a tapering plan or discontinuation plan to support the extended length of time.

Section I. Short-acting opioid Prior Authorization Criteria

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    - Prior authorization is required for adults (≥ 21 years of age) when more than a 5 day supply is prescribed (whether obtained from a single prescription or multiple prescriptions) in a 30 day period.
    - Prior authorization is required for children (< 21 years of age) when more than a 3 day supply is prescribed (whether obtained from a single prescription or multiple prescriptions) in a 30 day period.

Initial Criteria

xi. A pain assessment (type, cause, duration, severity of pain, etc.) is provided.
xii. A signed provider-patient pain management contract is submitted
xiii. Documentation the member has tried and failed or has an intolerance or contraindication to non-pharmacologic therapies (e.g. behavioral, cognitive, physical therapies, and in situations where covered, acupuncture and/or yoga).
xiv. Documentation the member has tried and failed or has an intolerance or contraindication to non-opioid analgesics (e.g. acetaminophen, NSAID, antidepressant, anticonvulsant).
xv. Documentation the short-acting opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
xvi. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Delaware Prescription Monitoring Program (DPMP) database for the member's controlled substance prescription history.
ii. Provider has evaluated the member for risk factors for opioid-related harm.
    1. If the member is identified at high risk for opioid related harm, the provider has educated the member on being a candidate for carrying naloxone.
xvii. Documentation the member, or parent/guardian, has been educated on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction.
xviii. Member is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined medically necessary. If taking concomitantly, physician must attest awareness of the black box warning associated with concurrent use of benzodiazepines and opioids.
xix. A recent UDS has been completed and results are consistent with prescribed controlled substances. If the UDS is not consistent, provider must state the results and resolution.
xx. Authorization length: up to three (3) months

Reauthorization criteria

ix. Documentation is submitted that shows an improvement in pain control and level of functioning. Rationale is provided for continued use of opioid therapy or a plan for taper/discontinuation.
x. Documentation the short-acting opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
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xii. Provider has evaluated the member for risk factors for opioid-related harm.
    1. If the member is identified at high risk for opioid related harm, the provider has educated the member on being a candidate for carrying naloxone.
xiii. Member is being monitored by the prescriber for adverse events and warning signs for serious problems, such as overdose and opioid use disorder.
xiv. Member is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined medically necessary. If taking concomitantly, physician must attest awareness of the black box warning associated with concurrent use of benzodiazepines and opioids.
xv. A UDS has been completed every 6 months and results are consistent with prescribed controlled substances. If the UDS is not consistent, provider must state the results and resolution.
xvi. Authorization length: up to six (6) months
    1. In situations when the request is deemed not medically necessary and the member is currently on chronic opioids and/or benzodiazepines, up to a three (3) month authorization will be granted to allow for tapering of medication(s).
    2. For members who require longer than a 3 month taper, the provider must submit either a tapering plan or discontinuation plan to support the extended length of time.

Section II. Long-acting opioid Prior Authorization Criteria

All long-acting opioids require prior authorization and will be screened for medical necessity and appropriateness using the prior authorization criteria listed below.

- Coverage may be provided for a **long-acting opioid** when the following criteria is met:

Initial Criteria

xiv. A pain assessment (type, cause, duration, severity of pain, etc.) is provided.
xv. A signed provider-patient pain management contract is submitted
xvi. Documentation the member has tried and failed or has an intolerance or contraindication to non-pharmacologic therapies (e.g. behavioral, cognitive, physical therapies, and in situations where covered, acupuncture and/or yoga).
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xviii. Documentation the long-acting opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
xix. Documentation the member has had a trial of at least one short-acting opioid.
xx. The long-acting opioid must be prescribed for ongoing continuous therapy. Long-acting opioids are not intended to be used on an as-needed (prn) basis.
xxi. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Delaware Prescription Monitoring Program (DPMP) database for the member's controlled substance prescription history.
xxii. Provider has evaluated the member for risk factors for opioid-related harm.
    1. If the member is identified at high risk for opioid related harm, the provider has educated the member on being a candidate for carrying naloxone.
xxiii. Documentation the member, or parent/guardian, has been educated on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction.
xxiv. Member is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined medically necessary. If taking concomitantly, physician must attest awareness of the black box warning associated with concurrent use of benzodiazepines and opioids.
xxv. A recent UDS has been completed and results are consistent with prescribed controlled substances. If the UDS is not consistent, provider must state the results and resolution.
xxvi. Authorization length: up to three (3) months

Reauthorization criteria

ix. Documentation is submitted that shows an improvement in pain control and level of functioning. Rationale is provided for continued use of opioid therapy or a plan for taper/discontinuation.
x. Documentation the long-acting opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
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xv. A UDS has been completed every 6 months and results are consistent with prescribed controlled substances. If the UDS is not consistent, provider must state the results and resolution.
xvi. Authorization length: up to six (6) months

1. In situations when the request is deemed not medically necessary and the member is currently on chronic opioids and/or benzodiazepines, up to a three (3) month authorization will be granted to allow for tapering of medication(s).
2. For members who require longer than a 3 month taper, the provider must submit either a tapering plan or discontinuation plan to support the extended length of time.

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- Coverage may be provided for quantities exceeding the threshold or quantity limit when the following criteria is met (in addition to the above prior authorization criteria, if applicable):
  viii. The prescribing provider, or the prescribing provider's delegate, confirms they have reviewed the Delaware Prescription Monitoring Program (DPMP) database for the member's controlled substance prescription history.
  ix. A signed provider-patient pain management contract is submitted
  x. A treatment plan, including clinical rationale to support medical necessity for the high dose, is provided.
  xi. For chronic pain diagnoses: If requesting high doses of short-acting opioids in the absence of a long-acting opioid, clinical rationale is provided for not utilizing a long-acting opioid.
  xii. For members meeting or exceeding 90 MME/day, the provider has educated the member on being a candidate for carrying naloxone.
  xiii. If requested dosing frequency exceeds the maximum FDA-approved dosing frequency, clinical rationale is provided to support medical necessity.
  xiv. Authorization length: up to six (6) months
    1. In situations when the request is deemed not medically necessary and the member is currently on chronic opioids and/or benzodiazepines, up to a three (3) month authorization will be granted to allow for tapering of medication(s).
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HIGHMARK. Delaware HEALTH OPTIONS

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OPIOID ANALGESICS
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any ***progress notes, laboratory test results, or chart documentation*** as applicable to Health Options Pharmacy Services. **FAX:** 1-855-476-4158
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Patient Name:	
Health Options ID:	DOB:

DRUG INFORMATION

Medication:	Strength & Frequency:
Quantity:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

BILLING INFORMATION

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

PLACE OF SERVICE INFORMATION

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis/diagnoses:

What is the suspected cause of pain (e.g. post-operative, neuropathic)?:

Current Regimen (including other analgesic medication/therapy, dose, frequency, duration)	**Proposed Regimen** (including other analgesic medication/therapy, dose, frequency, duration)

Is a pain assessment including the use of a pain assessment tool completed by the prescriber and attached?
☐ Yes ☐ No

Has the member or parent/guardian been educated on the potential adverse effects of opioid analgesics? ☐ Yes ☐ No

If the patient is at high risk for opioid related harm (exceeding 90 morphine milligram equivalents a day), has the member been educated on being a candidate for carrying naloxone? ☐ Yes ☐ No

Has the provider reviewed the patient's Prescription Monitoring Program (PMP) profile? ☐ Yes ☐ No

- If **yes,** were the other prescribers (including stimulants) contacted for coordination of controlled substances prescriptions? ☐ Yes ☐ No

If **no**, please explain:

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OPIOID ANALGESICS
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

MEDICAL HISTORY (Complete for ALL requests)

Is a signed provider-patient pain management contract attached? ☐ Yes ☐ No

Is the patient currently taking a benzodiazepine? ☐ Yes, provide diagnosis: _____ ☐ No

- If **yes**, will there be an attempt to taper off benzodiazepine therapy? ☐ Yes ☐ No
- If **no**, please provide clinical rationale for continuation while on opioid therapy:_____

The provider attests they are aware of the black box warning associated with concurrent use of benzodiazepines and opioids? ☐ Yes ☐ No

Has a urine drug screen been completed within the previous six months? ☐ Yes ☐ No

- Were the results consistent with current treatment and devoid of illicit substances? ☐ Yes ☐ No
- If **no**, please provide treatment plan and rationale for continuation of opioid therapy: _____

_____

PREVIOUS MEDICATIONS AND/OR THERAPIES TRIED

Has the member tried and failed either of the following? **If yes**, please provide more information below.
☐ Non-pharmacologic therapies (e.g., behavioral, cognitive, physical and/or supportive therapies)
☐ Medications (e.g., acetaminophen, NSAIDS, antidepressants, anticonvulsants)

Medication/Therapy Name	Dose/ Frequency	Dates Tried	Reason therapy failed, discontinued, or contraindicated

OPIOID TAPER PLAN

If taping the member's opioids, please detail the plan below including the intended duration:

ADDITIONAL SUPPORTING INFORMATION or CLINICAL RATIONALE

REAUTHORIZATION CRITERIA

- Is an updated pain assessment provided? ☐ Yes ☐ No
- Has the patient had an improvement in pain and function? ☐ Yes ☐ No
- If **no**, please provide a treatment plan and rational for continued use:_____

_____

Prescribing Provider Signature	Date