HIGHMARK HEALTH OPTIONS

Updated: 11/2025
DMMA Approved: 10/2025

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.

- Short-acting opioids require prior authorization when more than a 7-day supply is prescribed (whether obtained from a single prescription or multiple prescriptions) in a 30 day period.
- All long-acting opioids require 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. Prior Authorization Criteria

Coverage may be provided for an **opioid analgesic** when the following criteria is met:

Initial Criteria:

- A pain assessment (type, cause, duration, severity of pain, etc.) is provided.
- A signed provider-patient pain management contract is submitted
- 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).
- Documentation the member has tried and failed or has an intolerance or contraindication to non-opioid analgesics (e.g. acetaminophen, NSAID, antidepressant, anticonvulsant).
- Documentation the opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
- 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.
- If the member is identified at high risk for opioid related harm or exceeds 50 MME/day, the provider has educated the member on being a candidate for carrying naloxone.
- 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.
- 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.
- 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.
- For long-acting opioids:

  - Documentation the member has had a trial of at least one short-acting opioid.
  - 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.
- **Authorization length**: up to 3 months

Reauthorization criteria:

- 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.
- Documentation the opioid will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy.
- 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.
- If the member is identified at high risk for opioid related harm or exceeds 50 MME/day, the provider has educated the member on being a candidate for carrying naloxone.
- Member is being monitored by the prescriber for adverse events and warning signs for serious problems, such as overdose and opioid use disorder.
- 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.
- 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.
- **Authorization length:** up to 6 months
  - In situations when the request is deemed not medically necessary and the member is currently on chronic opioids and/or benzodiazepines, up to a 3 month authorization will be granted to allow for tapering of medication(s).
  - 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. 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 50 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):

- 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.
- A signed provider-patient pain management contract is submitted
- A treatment plan, including clinical rationale to support medical necessity for the high dose, is provided.

- 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.
- For members meeting or exceeding 50 MME/day, the provider has educated the member on being a candidate for carrying naloxone.
- If requested dosing frequency exceeds the maximum FDA-approved dosing frequency, clinical rationale is provided to support medical necessity.
- **Authorization length:** up to 6 months
    - In situations when the request is deemed not medically necessary and the member is currently on chronic opioids and/or benzodiazepines, up to a 3 month authorization will be granted to allow for tapering of medication(s).
    - 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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OPIOID ANALGESICS
PRIOR AUTHORIZATION FORM – PAGE 1 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 Mon – Fri 8 am to 7 pm

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

MEMBER INFORMATION		
Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION		
Medication:	Strength:	
Directions:	Quantity:	Refills:
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, 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:	ICD Code:
What is the suspected cause of pain (e.g. post-operative, neuropathic)?	
Current Regimen (including other analgesic medications & therapy, dose, frequency, duration)	**Proposed Regimen** (including other analgesic medications & therapy, dose, frequency, duration)

Has a pain assessment been completed and attached? ☐ Yes ☐ No
Has education been provided on the potential adverse effects of opioid analgesics? ☐ Yes ☐ No
If at high risk for opioid related harm (> 50 MME/day), has the member been educated on naloxone? ☐ Yes ☐ No

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

Has the Prescription Monitoring Program (PMP) profile been reviewed? ☐ Yes ☐ No
- If Yes, were other prescribers contacted for coordination of controlled substance prescriptions (including stimulants)? ☐ Yes ☐ No, please explain:

Is a benzodiazepine being taken also? ☐ Yes, diagnosis: _____ ☐ No
- If Yes, will there be an attempt to taper off the benzodiazepine? ☐ Yes ☐ No, provide clinical rationale for continuation while on concurrent opioid therapy:
- If Yes, does the provider attest that they are aware of the black box warning associated with concurrent benzodiazepine and opioid use? ☐ Yes ☐ No

Has a urine drug screen been completed within the past 6 months: ☐ Yes ☐ No
Were the results consistent with current treatment and devoid of illicit substances? ☐ Yes ☐ No, please provide plan and rationale for continuation of opioid therapy:

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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**
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MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

CURRENT or PREVIOUS THERAPY

What has been tried previously? Please check all that apply and 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	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

OPIOID TAPER PLAN

If tapering the opioids, please provide the plan including the intended duration:

REAUTHORIZATION

Is an updated pain assessment provided? ☐ Yes ☐ No

Has the member experienced improvement in pain and function? ☐ Yes ☐ No, provide a treatment plan and rationale for continued use:

ADDITIONAL SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date