Fidelis Care Opioid Prior Authorization Form

(3/2018)

This form and Fidelis Care formulary are available at https://www.fideliscare.org/en-us/providers/pharmacyservices.aspx

Instructions: THIS FORM IS NOT VALID WITHOUT SIGNATURE. To avoid unnecessary delays, please print neatly and complete in its entirety. Fax this form to **1-877-533-2405**. For questions call 1-888-FIDELIS (1-888-343-3547).
CDC Guidelines for Opioid prescribing for Chronic Pain: **OPIOIDS ARE NOT RECOMMENDED AS FIRST-LINE TREATMENT FOR CHRONIC PAIN**. Please see https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm for additional information.

Prior Authorization is required for:

1. Immediate-Release/Extended-Release Opioids exceeding a cumulative daily dose of 90 Morphine-Milligram Equivalents (MME)
2. Immediate-Release/Extended Release Opioids exceeding the Quantity Limit
3. New starts of Extended-Release Opioids require an initial trial of at least a 7 day supply of an immediate-release opioid analgesic (Commercial lines of business only)
4. New Immediate-Release opioid analgesics exceeding a 7 day supply without prior history of opioid use

Member Name *(last, first)* _____ **Member ID#** _____
Date of birth _____/_____/_____ **Sex Male ☐ Female ☐**
Prescriber Name _____ **Specialty** _____ **Contact Person**_____
Address _____ **City, ST, Zip** _____
Phone# _____ **Ext** _____ **Fax#** _____

Medication(s) Requested *(strength, route, frequency, duration, and quantity)*_____
_____
_____
_____

Current Diagnosis / ICD-10 and Other Significant Medical History *(attach medical chart notes)* _____
_____

Medical Justification *(to avoid delays, **SUBMIT CLINICAL CHART NOTES** supporting response to each question)*

1. Is the requested medication being prescribed for pain associated with cancer, a terminal condition, sickle cell, or is the member in hospice / palliative care? **Yes ☐ No ☐**
2. Is the requested medication being used to treat Acute Pain (pain lasting ***LESS THAN*** 90 days)? **Yes ☐ No ☐**
   (If yes, submit clinical rationale for use of opioid medication lasting longer than a 7 day supply) Is this medication being used to treat Chronic Pain (pain lasting ***MORE THAN*** 90 days)? **Yes □ No □**
3. Which non-opioid therapies has the member tried to treat their pain condition? *(submit clinical chart notes documenting trial history; formulary options available at https://www.fideliscare.org/en-us/providers/pharmacyservices.aspx)*
4. Does the member require a cumulative dose of opioids exceeding the recommended 90 (MME) per day? **Yes ☐ No ☐**
   (If yes, submit clinical chart notes documenting the underlying diagnosis related to pain, clinical rationale for high dose)
5. Has documentation of a positive urine drug screen been provided? **Yes ☐ No ☐**
6. Will benzodiazepines be excluded from the member's treatment plan in accordance with CDC recommendations **Yes ☐ No ☐**
   (By checking no, opioid prescriber acknowledges and approves concurrent use)
7. If member exhibits signs of opioid use disorder, will referral be made to a treatment program? **Yes ☐ No ☐**

90 Morphine Milligram Equivalents (MME)**			
Morphine	90 mg	Hydromorphone	22.5 mg
Hydrocodone	90 mg	Fentanyl Patch	37.5 MCG
Oxycodone	60 mg	Codeine	600 mg
Oxymorphone	30 mg	*** Equivalent doses are based on MME conversion factors from CDC Guidelines for Opioid Prescribing in Chronic Pain*	

URGENT REQUEST **CHECK ☐** If the request is for a life threatening condition that is dependent on a priority review from the Fidelis Care Pharmacy Department, you may request an expedited review. Please be considerate of other providers and patients who are also requesting prior authorization.

I attest that this information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a Medicaid MC claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts. As indicated in the NYSDOH Medicaid Update (2/201, Volume 3, No. 02), third party phone or fax requests will not be accepted. If a prescriber grants a pharmacy the authority to handle his/her PA requests, the prescriber's actions would be considered "patient steering," as this arrangement does not give the patient a choice as to where they go to get their drugs. Per the Medicaid Update, this action may be reported to the Office of Medicaid Inspector General.

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