Fidelis Care Opioid Prior Authorization Form (11/2017)

Instructions: Completion of this form is required for timely processing of the prescription. Complete and fax this form back to Fidelis Care at fax: **1-877-533-2405**. For questions or concerns, call 1-888-FIDELIS (1-888-343-3547). The prior authorization request form and Fidelis Formulary can be found at: https://www.fideliscare.org/en-us/providers/pharmacyservices.aspx

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

Member Information

Member Name: _____ **Date of Birth:** _____

Member ID: _____

Provider Information

Provider Name: _____

Provider Address: _____

Phone: _____ **Fax:** _____

Provider NPI#: _____

Provider DEA#: _____

Opioid Requested

Drug name: _____

Direction and max daily dose: _____

Diagnosis for use: _____

Medical Justification

1. Is this medication being used to treat Acute Pain (pain lasting ***LESS THAN*** 90 days)? **Yes** ☐ **No** ☐ *(If yes, please sign this form and provide clinical rationale for use of opioid medication lasting longer than a 7 day supply):*

   _____

   _____

2. Is the requested medication being prescribed for pain associated with cancer, a terminal condition, pain associated with sickle cell, or pain being managed through hospice or palliative care? **Yes** ☐ **No** ☐ (*If yes, please sign this form and submit clinical chart notes documenting the diagnosis. If no, complete the rest of the form*)

Medical Justification

3. Is this medication being used to treat Chronic Pain (pain lasting ***MORE THAN*** 90 days)? **Yes** ☐ **No** ☐
4. Include the clinical rationale for long-term opioid use, INCLUDING past medical history and any underlying conditions related to the patient's pain: _____
   _____
   _____
5. Has the patient tried any non-opioid therapies to treat their pain condition? (*Please see page 3 for a list of formulary, non-opioid medications*)

Drug (dose, route, frequency)	**Start Date**	**Stop Date**	**Reason for Discontinuation**

6. If requesting a non-preferred opioid product, has the patient failed an adequate trial of a preferred product? **Yes** ☐ **No** ☐ *(If yes, please list formulary medications tried)*

Drug (dose, route, frequency)	**Start Date**	**Stop Date**	**Reason for Discontinuation**

Treatment Plan

1. Is the requested drug being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid? **Yes** ☐ **No** ☐
2. Can the patient safely take the requested dose based on their history of opioid use? **Yes** ☐ **No** ☐
3. Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder? **Yes** ☐ **No** ☐
4. Will the patient's pain be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety? **Yes** ☐ **No** ☐
5. If patient exhibits any signs of opioid use disorder, will referral of patient to a substance use disorder treatment program be considered? **Yes** ☐ **No** ☐
6. If no to any of the above, please provide additional information or clinical rationale: _____
   _____
   _____

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 (such as cardiovascular conditions like arrhythmia), you may request an expedited review. Medications for hyperlipidemia, growth hormones, allergic rhinitis, and other non-urgent use will be completed within 3 days and will NOT be expedited. Please be considerate of other providers and patients who are also requesting prior authorization.

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

Formulary Non-Opioid Treatment options for Chronic Pain Conditions

(The most up to date full formulary can be found at https://www.fideliscare.org/Portals/0/DocumentLibrary/Providers/Pharmacy%20Services/FidelisFormularyFull2017.pdf):

1. **Chronic low Back Pain (with or without Radiculopathy)**
    a. Oral Nonsteroidal Anti-inflammatory Drugs (NSAIDs)
    b. Diclofenac 1% Gel
    c. Celecoxib
    d. Non-Pharmacologic: Physical Therapy (PT), Occupational Therapy (OT)

2. **Acute Low Back Pain**
    a. Musculoskeletal Agents
    b. Lidocaine 2% Gel & Lidocaine 4% Solution
    c. Corticosteroid Injections

3. **Neuropathic Pain (including Diabetic Neuropathy, Post-Herpetic Neuralgia, Fibromyalgia)**
    a. **SNRI's:** Duloxetine, Venlafaxine
    b. **Tricyclic Antidepressants:** Amitriptyline, Nortriptyline
    c. **Anticonvulsants**: Gabapentin, Lyrica*
        i. ** Lyrica requires step-therapy or prior authorization*
    d. Cyclobenzaprine
    e. Savella
    f. Lidocaine 2% Gel & Lidocaine 4% Solution

4. **Osteoarthritis**
    a. Oral Nonsteroidal Anti-inflammatory Drugs (NSAIDs)
    b. Diclofenac 1% Gel
    c. Celecoxib
    d. Duloxetine

90 Morphine Milligram Equivalents (MME)**

Opioid Medication	Equivalent Dose
Morphine	90 mg
Hydrocodone	90 mg
Oxycodone	60 mg
Oxymorphone	30 mg
Hydromorphone	22.5 mg
Fentanyl Patch	**37.5 MCG**
Codeine	600 mg

*** Equivalent doses are based on MME conversion factors from CDC Guidelines for Opioid Prescribing in Chronic Pain*