

Prior Authorization Form

Acute Opioid Use: Up to 15 Days' Supply

INSTRUCTIONS FOR COMPLETING THIS FORM

Refer to the [Opioid Criteria – Acute, Chronic, and Exceptions](#) for clinical criteria requirements for short and long-acting opioids. Please fill out all sections on all pages completely and legibly. If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Use one form per member, per drug, please. This form, along with other PA forms can be found at: <https://welcome.optumrx.com/tenncare/landing>.

MEMBER INFORMATION

Member Last Name: _____
 Member First Name: _____
 Member ID: _____
 Date of Birth (MM/DD/YYYY): _____ Sex: ☐ Male ☐ Female
 Street Address: _____
 City: _____ State: _____ ZIP: _____
 Phone Number: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____
 Prescriber First Name: _____
 Prescriber NPI: _____ Prescriber DEA: _____
 Specialty: _____ Office Phone: _____ Office Fax: _____
 Supervising Physician and DEA (if applicable): _____
 Office Street Address: _____
 City: _____ State: _____ ZIP: _____
 Is the prescriber a single patient contract holder for this patient? ☐ Yes ☐ No
 Is the prescriber a TennCare provider with a TN Medicaid ID? ☐ Yes ☐ No

TennCare Rule: 1200-13-13-.04(1)(c)12 confines acute narcotic prescription coverage for non-chronic opioid users up to a maximum of 15 days in any 180-day period not to exceed 60 MME (morphine milligram equivalents) per day. The first fill prescription cannot exceed 5 days. Prior Authorization is required for all subsequent acute prescriptions after the first fill. Information and separate PA forms for clinical exceptions (e.g. burn or corrosion, sickle cell disease, use in LTC facilities, and cancer undergoing active treatment, hospice care) can be found on the Optum Rx/TennCare website at: [Optum Rx/TennCare website](#).

Requests for Acute Opioid Users are limited to 60 MME per day. The current [MME Conversion Chart](#) is posted on the Optum Rx/TennCare website.

With the exception of the “[Branded Drugs to be Classified as Generics List](#),” TennCare is a mandatory generic program in accordance with state law (TCA 53-10-205). Approval of Non-Preferred agents requires trial and failure, contraindication, or intolerance of two (2) preferred agents, unless otherwise indicated on the [Preferred Drug List \(PDL\)](#).

This document and others if attached contain information that is privileged, confidential, and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Optum Rx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing, or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Member Last Name: _____ DOB: _____

MEDICATION AND DISPENSING INFORMATION

Drug Name: _____ Drug strength: _____
Drug Formulation: _____ Dosing Frequency: _____
Quantity: _____ Day Supply: _____

Please refer to the [Preferred Drug List](#) or see below for Preferred and Non-Preferred Drugs in the Narcotic, Short-Acting class.

Narcotics, Short-Acting

Preferred Drugs	Non-Preferred Drugs
codeine/APAP ^{PA < 18 years, QL}	Apadaz® ^{QL}
Endocet® ^{QL}	benzhydrocodone/APAP ^{PA, QL}
hydrocodone/APAP 325 mg ^{QL}	butalbital/APAP/caff/codeine ^{PA, QL}
hydrocodone/ibuprofen ^{QL}	butalbital/ASA/caff/codeine ^{PA, QL}
hydromorphone tabs ^{QL}	codeine ^{PA, QL}
morphine IR tabs ^{QL}	dihydrocodeine/APAP/cafeine ^{PA, QL}
morphine soln ^{PA, QL}	Dilaudid® ^{PA, QL}
oxycodone/APAP 325 mg ^{QL}	Fioricet® with codeine ^{PA, QL}
oxycodone conc ^{PA, QL}	hydrocodone/APAP 300 mg ^{PA, QL}
oxycodone tabs ^{QL}	hydromorphone liquid ^{PA, QL}
oxycodone soln ^{QL}	hydromorphone suppositories ^{PA}
tramadol ^{PA < 18 years, QL}	levorphanol ^{PA, QL}
tramadol/APAP ^{PA < 18 years, QL}	meperidine ^{PA, QL}
	morphine suppositories ^{PA, QL}
	Nalocet® ^{PA, QL}
	oxycodone/APAP 300 mg ^{QL}
	oxycodone caps ^{PA, QL}
	oxymorphone ^{PA, QL}
	Percocet® ^{PA, QL}
	Prolate® ^{PA, QL}
	Qdolo® ^{PA, QL}
	Roxicodone® ^{PA, QL}
	Roxybond® ^{PA, QL}
	tapendatol IR tabs ^{PA, QL}

MME CALCULATION

Requests for Acute Opioid Users are limited to 60 MME per day. The current [MME Conversion Chart](#) is posted on the Optum Rx/TennCare website.

Daily MME Formula = $\frac{\text{Strength} \times \text{Conversion Factor} \times \text{Quantity of units}}{\text{Days' Supply of Rx}}$

Please calculate all short-acting narcotic agents and dosages with MME conversion that the patient may be receiving below to obtain the total daily MME. Please list all short and long-acting opioids the patient is currently taking:

Drug Name & Strength: _____ Daily MME: _____
Drug Name & Strength: _____ Daily MME: _____
Drug Name & Strength: _____ Daily MME: _____
Drug Name & Strength: _____ Daily MME: _____
Drug Name & Strength: _____ Daily MME: _____
Total MME patient currently receiving for all opioid agents: _____

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CLINICAL CRITERIA

1. Does the patient have moderate to severe acute pain requiring treatment beyond an initial first-fill opioid prescription? ☐ Yes (indicate diagnosis below) ☐ No
 - a. Diagnosis (Specify and list ICD-10 code: _____)
2. Have non-pharmacologic therapies been considered? ☐ Yes ☐ No
3. Has the patient tried non-opioid analgesic treatment? ☐ Yes (If yes, please document below) ☐ No
 - a. Non-Opioid Analgesic: _____
 - i. Dates: _____
 - ii. Response: _____
 - b. Non-Opioid Analgesic: _____
 - i. Dates: _____
 - ii. Response: _____
 - c. Non-Opioid Analgesic: _____
 - i. Dates: _____
 - ii. Response: _____
4. Does the patient's pain significantly impair their physical functioning (e.g., ADLs, sleep, work)? ☐ Yes ☐ No
5. Is the patient currently being treated for opioid addiction? ☐ Yes ☐ No
6. The overutilization of opioid analgesics has been associated with increased risk of opioid use disorder and overdose.
 - a. For patients > 18 years of age, has the provider assessed the member using a Screening, Brief Intervention, and Referral to Treatment (SBIRT) questionnaire (e.g., [SBIRT survey](#))? ☐ Yes ☐ No
 - b. For patients 11-18 years of age, has the provider assessed the member using an adolescent Screening, Brief Intervention, and Referral to Treatment (SBIRT) questionnaire (e.g., [SBIRT CRAFFT survey](#))? ☐ Yes ☐ No
7. Will this patient be using benzodiazepines and opioids concomitantly? ☐ Yes ☐ No
 - a. If yes, is the patient under the care of or been referred to a mental health provider? ☐ Yes ☐ No
8. For requests for non-preferred agents, does the patient have a reason they cannot use all preferred agents?
☐ Yes ☐ No
 - a. If yes, please provide details: _____

9. Please answer this question for childbearing age female patients (age 14-44 years).
 - a. Is the patient pregnant? ☐ Yes ☐ No
 - i. If yes, does the prescriber attest to each of the following:
 - Alternate treatment options are ineffective or not appropriate ☐ Yes ☐ No
 - The lowest effective dose for the shortest duration will be prescribed ☐ Yes ☐ No
 - The patient has been counseled on risks associated with Neonatal Abstinence Syndrome (NAS) ☐ Yes ☐ No
 - ii. If no, please check all that apply:
 - ☐ Patient is using contraception
 - ☐ Patient has an intrauterine device (IUD) or other long-acting reversible contraceptive device (LARC), such as an implant
 - ☐ Patient has history of hysterectomy, tubal ligation, or endometrial ablation
 - ☐ Patient has been counseled on the risk of Neonatal Abstinence Syndrome (NAS) if pregnancy occurs while using opioid therapy.

Member Last Name: _____ DOB: _____

10. Please answer this question for requests for opioid/acetaminophen combination products if the total acetaminophen dose is between 3,000 and 4,000 mg per day.

- a. Does the patient have hepatitis? ☐ Yes ☐ No
- b. Does the patient have liver cirrhosis? ☐ Yes ☐ No
- c. Does the patient have chronic alcoholism? ☐ Yes ☐ No
- d. Does the patient have hepatic insufficiency? ☐ Yes ☐ No

PRESCRIBER SIGNATURE

By signing below, the prescriber certifies that the benefits of opioid treatment for this patient outweigh the risks and verifies that the information provided on this form is true and accurate to the best of my knowledge.

By signature, the prescriber confirms the above information is accurate and verifiable by patient records.

Prescriber Signature: _____ Date: _____

INSTRUCTIONS FOR SUBMISSION

PA requests can be submitted to Optum Rx via fax (866-434-5523), by phone (866-434-5524), or by electronic PA request, such as CoverMyMeds. For questions, please call 1-866-434-5524. Optum Rx will provide a response within 24 hours upon receipt.