PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Virginia Premier Opioid Review

Phone: **Fax back to: 866-754-9616**
Medallion 855-872-0005
VPEPLUS 844-838-0711

Is this REQUEST for: ☐ **Short-Acting Opioid** ☐ **Long-Acting Opioid** ☐ **BOTH (check all that apply)**

Prior Authorization is required for:

1) **All Long Acting Opioids**
2) **Any Short-Acting Opioid prescribed for > 7 days or two (2) 7 day supplies in a in a 60 day period.** ***The Virginia BOM Regulations limit the treatment of acute pain with opioids to 7 days and post-op pain to no more than 14 days.***
3) **Any cumulative opioid prescription exceeding 120 morphine milligram equivalents (MME) per day. Quantity limits apply to each drug. (https://client.formularynavigator.com/Search.aspx?siteCode=0329244788)**

Long-Acting Opioids Prior Authorization (PA). Indicated for patients with chronic, moderate to severe pain who require daily, around-the-clock, chronic opioid treatment. Patients with a history of substance use disorder should be considered for Buprenorphine analgesic treatment with either topical patch or buccal film. These products have a ceiling effect with less risk of respiratory depression than other opioids.

Patient Name:	**Prescriber Name:**
Member/Subscriber Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

Drug Name and Strength: ☐ Expedited/Urgent

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Alternative Therapy to Schedule II Opioids. Based on the the Virginia Board of Medicine's Opioid Prescribing Regulations, Opioids are NOT recommended as first line treatment for acute or chronic pain. For additional information please see:
https://www.dhp.virginia.gov/medicine/leg/PrescribingOpioidsBuprenophine_03152017.doc

Preferred Alternative Products: NSAIDS topical and oral, SNRIs Tricyclic Antidepressants, Gabapentin, Baclofen, Capsaicin topical cream 0.025%, Lidocaine Patch 5%. Pregabalin (Lyrica®) is available after a trial and failure of gabapentin and duloxetine. Buprenorphine Transdermal Patch (Butrans®), or Buprenorphine Buccal Film (Belbuca™) Consider alternative therapy to Schedule II opioid drugs due to their high potential for abuse and misuse. Complete list of VPHP Medicaid formulary can be found at:
https://client.formularynavigator.com/Search.aspx?siteCode=0329244788

Q1. Does prescriber attest that the patient has intractable pain associated with active cancer, end-of-life care? (IF YES PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless requesting a non-preferred/non-formulary drug. See Q6).

☐ Yes ☐ No

Q2. Is the patient is in remission from cancer, and prescriber is safely weaning patient off of opioids with a tapering plan? (IF YES PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless requesting a non-preferred/non-formulary drug. See Q6).

☐ Yes ☐ No ☐ N/A

Q3. Is member in a long-term care facility? (IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless a non-preferred/non-formulary drug is prescribed. See Q6 if non-formulary drug is

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

prescribed.)

☐ Yes ☐ No

Q4. Is this medication used to treat:

☐ Acute Pain (less than 90 days)
☐ Post-operative Pain
☐ Chronic Pain (90 days or greater)

Q5. REQUIRED: Please indicate if the patient has tried and failed any of the following (select all that apply):

☐ Baclofen
☐ NSAIDs (oral)
☐ Gabapentin
☐ Duloxetine/Tricyclic Antidepressant
☐ Carbamazepine
☐ Capsaicin Gel/Lidocaine 5% Patch
☐ Butrans/Belbuca
☐ 2 week trial of immediate release opioid

Q6. REQUIRED: If requesting a non-preferred product (i.e. Avinza, Kadian, Embeda, Xtampza, Oxyado, Hydromorphone ER, levorphanol, Morphine ER CAPSULE), has patient tried and failed an adequate trial of preferred product?

☐ Yes ☐ No ☐ N/A

Q7. If yes please list drug name, length of trial, and reason for discontinuation:

Q8. REQUIRED: Please provide the patient's Active Daily MME from the PMP (https://virginia.pmpaware.net/login):

Q9. REQUIRED: If member's Active Daily MME greater than or equal to 120, does the prescriber attest that he/she will be managing the member's opioid therapy long term, has reviewed the Virginia BOM Regulations for Opioid Prescribing, has prescribed naloxone, and acknowledges the warnings
associated with high dose opioid therapy including fatal overdose, and that therapy is medically necessary for this member?

☐ Yes ☐ No

Q10. REQUIRED: Please provide patient's last fill date of Opioid
prescription from the PMP (https://virginia.pmpaware.net/login):

Q11. REQUIRED: Please provide patient's last fill date of Benzodiazepine prescription from the PMP (https://virginia.pmpaware.net/login):

Q12. If benzodiazepine filled in past 30 days, does the prescriber attest that he/she has counseled the member on the FDA black box warning on the dangers of prescribing Opioids and Benzodiazepines including fatal overdose, has documented that the therapy is medically necessary, and has recorded a tapering plan to achieve the lowest possible effective doses of both opioids and benzodiazepines per the Board of Medicine Opioid Prescribing Regulations?

☐ Yes

☐ No
☐ Not Applicable (No Benzo filled)

Q13. REQUIRED: Has naloxone been prescribed for members with risk factors of prior overdose, substance use disorder, doses in excess of 120 MME/day, or concomitant benzodiazepines? ☐ Yes ☐ No
Q14. If member is female between 18-45 years old, has the prescriber discussed risk of neonatal abstinence syndrome and provided counseling on contraceptive options? ☐ Yes ☐ No ☐ N/A
Q15. REQUIRED: For chronic pain, has the prescriber ordered and reviewed a urine drug screen (UDS) or serum medication level prior to initiating treatment with short or long-acting opioids? ☐ Yes ☐ No ☐ N/A
Q16. REQUIRED: For PA renewals, has the prescriber ordered and reviewed a urine drug screen (UDS) or serum medication level at least every 3 months for the first year of treatment and at least every 6 months thereafter to ensure adherence? ☐ Yes ☐ No ☐ N/A

____________________________ ____________________

Prescriber Signature Date

Patient Utilization Management and Safety (PUMS) Program

Virginia Premier Health Plan (Virginia Premier) has a Patient Utilization Management & Safety (PUMS) program in place. The program makes sure that members are getting the proper health care, especially when it comes to patient safety.

PUMS Program Goal:
PUMS deals with prescription drugs as well as other kinds of health care, making certain the member is getting treatment that is proper and safe. Virginia Premier's clinical staff reviews our members' use of health care services to see whether they should be in the PUMS program. For members in the PUMS program, Virginia Premier takes extra steps to make sure they use services safely.

Being considered for PUMS does NOT mean a member has done anything wrong.
For any member who may be at risk for unsafe services, Virginia Premier must review whether the member should be in the PUMS program. In cases involving buprenorphine use, the member will automatically be in the PUMS program.

How Might PUMS Change a Member's Care?
Virginia Premier may offer case management services. Virginia Premier could set a single doctor for controlled substances to see the member, or a single pharmacy to provide controlled substance prescription drugs.
PUMS Member Rights: Virginia Premier will send every PUMS member a letter about the program. The letter will make clear how the member can get emergency care. The letter will also tell them how they can appeal being placed in the PUMS program.

PLEASE NOTE: Virginia Premier's doctors and pharmacists now use the Prescription Monitoring Program (PMP). The PMP helps them make sure that prescription drugs are used safely. Among other Patient Utilization Management & Safety (PUMS) triggers we review patients who have:

High Average Daily Dose: $\geq$ 90 cumulative morphine milligram equivalents (MME) per day over the past 90 days.

And/or

Concurrent use of Opioids and Benzodiazepines– at least 1 Opioid claim and 14 day supply of Benzo (in any order)

Our approach is to work collaboratively with patients and providers to ensure safe and appropriate use of controlled substances. We utilize and promote:

A) PMP Checks
B) Letter to Doctor & Member
C) Soft and Hard Pharmacy edits for Benzodiazepine and Opioid utilization
D) Following CDC Opioid Guidelines

E) Case Management as appropriate

We greatly appreciate your collaboration and Health Care service to our members. As part of our PUMS safety review we hope to collaborate with you for complete patient information with the goal of validating safe and appropriate controlled substance use and coordinated patient care.

RESPECTFULLY, VIRGINIA PREMIER CLINICAL STAFF

Non-opioid Treatment Options for Common Chronic Pain Conditions

Non-invasive Low back pain treatment recommendations:[i]

- Acute (with or without radiculopathy):
  - 1st Line (Non-pharmacologic): Keep in mind excellent natural history of disease. Acupuncture, massage, superficial heat shown to improve pain or function. Also consider pilates, tai-chi, yoga, psychology referral.
  - 2nd Line (pharmacologic): NSAIDs, skeletal muscle relaxer
- Chronic (with or without radiculopathy):
  - 1st Line (Non-pharmacologic): Exercise, motor control exercises, tai-chi, yoga, psychology referral, multi-disciplinary rehabilitation, acupuncture, massage
  - 2nd Line (pharmacologic): NSAIDs, duloxetine

Post-herpetic neuralgia:[ii]

- Topical (1st line for mild pain): 5% lidocaine patch, capsaicin cream or patch
- Systemic: gabapentin, pregabalin*, amitriptyline, nortriptyline

Diabetic neuropathy:[iii]

- 1st Line: pregabalin
- 2nd Line: gabapentin, venlafaxine (SNRI), duloxetine, amitriptyline (TCA), capsaicin 0.075% cream

Fibromyalgia:[iv]

- Non-pharmacologic: Patient education (pertaining to lack of disease progression, lack of tissue damage), cognitive behavioral therapy (CBT), and cardiovascular exercise
- Pharmacologic: amitriptyline and cyclobenzaprine (TCAs), duloxetine (SNRI), gabapentin, pregabalin* (gabapentinoids), fluoxetine, sertraline, paroxetine (SSRIs)
- No evidence for use of opiates in fibromyalgia

Migraines:[v]

- Acute Treatment
  - Mild – Moderate: acetaminophen, NSAIDs, caffeine, anti-emetics
  - Severe: triptans, ergots, prochlorperazine, promethazine
- Preventative Treatment
  - Propranolol, timolol, divalproex sodium, topiramate (Level A efficacy)
  - Opiates can cause medication overuse headache

Osteoarthritis:[vi]

- Non-pharmacologic: Exercise, weight loss, water-based exercise, wedged insoles, walking aides, splints
- Pharmacologic: Topical capsaicin, topical NSAIDs (preferred age > 75), oral NSAIDs (non-selective or COX-2 selective), intraarticular corticosteroid injection, consider duloxetine

*Pregabalin requires a trial and failure of gabapentin or duloxetine

[i]Qaseem A, Wilt TJ, McLean RM, Forciea MA, for the Clinical Guidelines Committee of the American College of Physicians. Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians. Ann Intern Med. 2017;166:514-530. doi: 10.7326/M16-2367

[ii] Johnson RW, Rice ASC. Clinical Practice: Postherpetic Neuralgia. N Engl J Med 2014;371:1526-33.

[iii] Griebeler ML, Morey-Vargas OL, Brito JP, Tsapas A, Wang Z, Carranza Leon BG, et al. Pharmacologic Interventions for Painful Diabetic Neuropathy: An Umbrella Systematic Review and Comparative Effectiveness Network Meta-analysis. Ann Intern Med. 2014;161:639-649. doi: 10.7326/M14-0511

[3]Bril V, England J, Franklin GM, et al. Evidence-based guideline: Treatment of painful diabetic neuropathy: Report of the American Academy of Neurology, the American Association of Neuromuscular and Electrodiagnostic Medicine, and the American Academy of Physical Medicine and Rehabilitation . Neurology. 2011;76(20):1758-1765. doi:10.1212/WNL.0b013e3182166ebe.

[iv] Clauw DJ. FibromyalgiaA Clinical Review. JAMA. 2014;311(15):1547-1555. doi:10.1001/jama.2014.3266

[v] MacGregor EA. Migraine. Ann Intern Med. 2013;159:ITC5-1. doi: 10.7326/0003-4819-159-9-201311050-01005

[vi] Hochberg MC, Altman RD, April KT, et al. American College of Rheumatology 2012 recommendations for the use of nonpharmacologic and pharmacologic therapies in osteoarthritis of the hand, hip, and knee. Arthritis Care Res (Hoboken). 2012 Apr;64(4):465-74