aetna™

Aetna Better Health®

Fax completed prior authorization request form to 877-309-8077 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at
www.aetnabetterhealth.com/pennsylvania/providers/pharmacy

Opioids
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information				
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female		Height:
Member ID:	City:	State:		Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information		
Preferred Long Acting Agents:	☐ Morphine Sulfate ER tablets	☐ Fentanyl Patch (except half strengths)
	☐ methadone	☐ oxymorphone extended release
Non-Preferred Long Acting Agents:	Specify drug:	
Short Acting Opioid:	Specify drug:	

Are there any contraindications to formulary medications? (if yes, please specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Medication request is NOT for an FDA-approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:
What medication(s) have been tried and failed for this diagnosis? Please specify:		

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information						
Pain is due to ONE of the following:	☐ Active Cancer	☐ Sickle Cell	☐ Palliative/End of life	☐ Hospice	☐ N/A	
Will member be on both opioid AND benzodiazepine at same time?	☐ Yes	☐ No	Will Naloxone be provided/offered?	☐ Yes	☐ No	☐ N/A
Is request for opioid naïve member?	☐ Yes	☐ No	Is member opioid tolerant?	☐ Yes	☐ No	☐ N/A
Was non-pharmacologic therapy tried PRIOR to prescribing opioids (PT, exercise, CBT OR weight loss)?				☐ Yes	☐ No	
Was non-opioid therapy tried PRIOR to prescribing opioids? (topical diclofenac NSAIDs, TCAs, and				☐ Yes	☐ No	

SNRIs OR anticonvulsants)												
Signed treatment plan addresses the following (check that apply):	☐ Realistic goals for pain AND function	☐ When treatment will be stopped	☐ Consequences of lost medication	☐ Consequences of obtaining controlled substances from other prescribers	☐ Member using ONE pharmacy							
Was member advised of harm AND benefits before treatment AND periodically during treatment (increased risks of respiratory depression, combination use with BNZ, risks to others in household, cognitive limitations AND side effects)?									☐ Yes	☐ No		
Will treatment be prescribed at lowest effective dose?									☐ Yes	☐ No		
Will treatment be reviewed within 1-4 weeks of starting opioid therapy for CHRONIC pain AND with any DOSE-ESCALATION AND RE-EVALUATED every 3 months?									☐ Yes	☐ No		
Was there review of state's PMP Drug Monitoring Program for controlled substances, with focus on opioid dosages OR dangerous combinations?									☐ Yes	☐ No		
Was UDS reviewed prior to starting treatment?		☐ Yes	☐ No	Were results of UDS consistent with prescribed controlled substances?					☐ Yes	☐ No		
Is there evidence of substance use disorder?	☐ Yes	☐ No	Was evidence-based treatment arranged (for example MAT)?		☐ Yes	☐ No	☐ N/A					
Is request for female of reproductive age?	☐ Yes	☐ No	Was counseling provided about opioid use during pregnancy AND neonatal abstinence syndrome?		☐ Yes	☐ No	☐ N/A					
Additional Clinical Information												
☐ **Long Acting Opioids**												
Will member exceed 90 MME per day limit?	☐ Yes	☐ No	Was documentation submitted to support exceeding recommended limit?		☐ Yes	☐ No	☐ N/A					
Was pain specialist consulted?		☐ Yes	☐ No	☐ N/A	Is request for chronic pain?				☐ Yes	☐ No		
Was treatment initiated with IR opioid for at least 2 weeks prior to considering ER/LA opioid?									☐ Yes	☐ No		
Is request for oxymorphone ER?	☐ Yes	☐ No	Was there inadequate response OR intolerance to 2 formulary LA opioids for 2 weeks?						☐ Yes	☐ No		
Is request for buprenorphine weekly patch?	☐ Yes	☐ No	Is there need for opioid with lower risk for abuse and a noted concern that member OR member's household is at risk for abuse AND diversion?						☐ Yes	☐ No		
Is request for non-formulary agent?	☐ Yes	☐ No	Was there inadequate response OR intolerance to oxymorphone ER AND 2 formulary LA opioids for 2 weeks?						☐ Yes	☐ No		
Is request for abuse-deterrent product?	☐ Yes	☐ No	Was there trial AND failure with buprenorphine patch for at least 2 weeks?						☐ Yes	☐ No		
			Is there NEED for abuse deterrent product AND concern that member OR household is at risk?						☐ Yes	☐ No		
Is request for methadone?	☐ Yes	☐ No	Is female member pregnant?		☐ Yes	☐ No	☐ N/A					
☐ **Short Acting Opioids**												
Will member exceed 90 MME per day limit?	☐ Yes	☐ No	Was there documentation to support medical necessity of exceeding recommended MME, or day supply limit?						☐ Yes	☐ No	☐ N/A	
Is request for non-formulary short-acting agent?	☐ Yes	☐ No	Was there inadequate response OR intolerance to 2 formulary short-acting opioids?						☐ Yes	☐ No		
Was documentation submitted supporting continued use of a SHORT ACTING AGENT beyond 30 days AND when used in combination with LONG-ACTING agent?									☐ Yes	☐ No		
☐ **Acute Pain in Pediatric Members (< 18 years of age)**												
Is request for acute pain (post-dental procedure)?		☐ Yes	☐ No	Was a pain assessment completed?					☐ Yes	☐ No		
Has member AND their parent(s)/guardian(s) been screened for previous AND current opioid use?									☐Yes	☐ No		
Provider has checked state's PMP Drug Monitoring Program for controlled substances with focus on opioid dosages									☐Yes	☐ No		

AND dangerous combinations?						
Concomitant use with BNZ has been appropriately addressed if present?	☐ Yes	☐ No	☐ N/A			
Combination therapy with APAP and NSAIDs were tried AND failed OR there are C/I present for use of both?					☐Yes	☐ No
Opioid therapy will be used in combination with APAP and NSAIDs unless there are C/I present for use of both?					☐Yes	☐ No
Member is NOT <12 years of age IF medication prescribed is **codeine or tramadol** (NOTE: use of these medications is C/I in children younger than 12 AND not recommended in those aged 12 – 17.)?			☐ Yes	☐ No	☐ N/A	
Will prescription will be limited to 8 – 12 tablets?			☐ Yes	☐ No		
Will IR opioids will be prescribed, limited to lowest effective dose AND no quantity greater than expected pain duration that is severe enough to require opioids will be given (NOTE: 3 days or fewer is recommended by CDC)?					☐ Yes	☐ No

☐ **Renewal ONLY**						
Was there sustained improvement in Pain OR Function?	☐ Yes	☐ No	Was tapering plan initiated to D/C treatment of current medication?	☐ Yes	☐ No	☐ N/A
Was UDS performed in past year?		☐ Yes		☐ No		
The state's PMP was reviewed AND verified (check that apply):	☐ Prescriptions from other providers	☐ Benzodiazepines use	☐ ER / LA use for acute pain	☐ UDS is consistent with prescribed controlled substances		

Is dose ≥50 MME per day?	☐ Yes	☐ No	Did provider offer Naloxone to member?	☐ Yes	☐ No	☐ N/A
Is dose ≥90 MME per day?	☐ Yes	☐ No	Did provider refer member to Pain Specialist?	☐ Yes	☐ No	☐ N/A
Is there continued concomitant use of opioid AND BNZ?	☐ Yes	☐ No	Was member counseled on FDA BBW dangers of concomitant use AND provider will prescribe at LOWEST effective dosage AND duration?	☐ Yes	☐ No	☐ N/A

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call to check the status of a request.
Pennsylvania CHIP:1-800-822-2447.