MISSISSIPPI DIVISION OF MEDICAID

STANDARDIZED ONE PAGE PHARMACY PRIOR AUTHORIZATION FORM

Mississippi Division of Medicaid, Pharmacy Prior Authorization Unit,
550 High St., Suite 1000, Jackson, MS 39201

☐ **Medicaid Fee for Service**/Change Healthcare
Fax to: 1-877-537-0720 Ph: 1-877-537-0722
https://medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/

☐ **Magnolia Health**/Envolve Pharmacy Solutions
Fax to: 1-877-386-4695 Ph: 1-866-399-0928
https://www.magnoliahealthplan.com/providers/pharmacy.html

☐ **UnitedHealthcare**/OptumRx
Fax to: 1-866-940-7328 Ph: 1-800-310-6826
http://www.uhccommunityplan.com/health-professionals/ms/pharmacy-program.html

☐ **Molina Healthcare**/CVS Caremark
Fax to: 1-844-312-6371 Ph: 1-844-826-4335
http://www.molinahealthcare.com/providers/ms/medicaid/pages/home.aspx

BENEFICIARY INFORMATION	
Beneficiary ID: ____ ____ ____ - ____ ____ ____ - ____ ____ ____	**DOB:____ ____/____ ____/____ ____ ____ ____**
Beneficiary Full Name:	
PRESCRIBER INFORMATION	
Prescriber's NPI:	
Prescriber's Full Name:	**Phone:**
Prescriber's Address:	**FAX:**
PHARMACY INFORMATION	
Pharmacy NPI:	
Pharmacy Name:	
Pharmacy Phone:	**Pharmacy FAX:**

CLINICAL INFORMATION

Requested PA Start Date:_____ Requested PA End Date:_____

Drug/Product Requested:_____ Strength:_____ Quantity:_____

Days Supply:_____ RX Refills:_____ Diagnosis or ICD-10 Code(s):_____

☐ **Hospital Discharge** ☐ **Additional Medical Justification Attached**

Medications received through coupons and/or samples are not acceptable as justification

PLEASE COMPLETE AND FAX DRUG SPECIFIC CRITERIA/ADDITIONAL DOCUMENTATION FORM FOUND BELOW

Prescribing provider's signature (signature and date stamps, or the signature of anyone other than the provider, are not acceptable)

I certify that all information provided is accurate and appropriately documented in the patient's medical chart.

Signature required: _____ Date: _____

Printed name of prescribing provider:_____

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PRIOR AUTHORIZATION DESCRIPTION

OPIOID PRIOR AUTHORIZATION CRITERIA- Effective August 1, 2019

- **Patients with a diagnosis of cancer or sickle-cell disease are exempt from edits (A-C) but are subject to edit (D) below.**
- **To ensure that prescriptions process for these patients, please denote the patient's diagnosis code on the prescription.**

A. SHORT-ACTING OPIOIDS

New opioid prescriptions (first opioid fill within 90 days) **for opiate-naïve patients must be for short-acting (SA) opioid. For new starts** (first opioid fill within 90 days) **a SA opioid can be filled for a maximum of two 7-day supplies in a 30 day period.** Use of SA opioids for longer periods will require a manual PA.*

1. **For Opioid-Naïve Patients**

   An opioid-naïve patient is defined as not having filled an opioid prescription in each month of the past three months. **Patients will be limited to two 7-day supplies** in a rolling 30 days and less than 90 morphine equivalent daily dose (MEDD) cumulative dose for their opioid fill. Any requests for traumatic injury/post-operative use of, short-acting opioids cannot exceed a single 7-day supply without medical justification. Opioid-naïve members may receive greater than any of the following: (1) Mississippi Medicaid's quantity limit (2) ≥90 MEDD (3) > a 7 day supply (4) additional prescriptions after the two- seven days' supply with a prior authorization when the prescriber attests to the following:

   a. The beneficiary's history on the Prescription Monitoring Program (PMP) has been evaluated and continues to be evaluated on a regular basis.
   b. (If applicable) I, the prescriber initiating or maintaining concomitant opioid and benzodiazepine therapy, acknowledge the risk of adverse events such as respiratory depression, coma, and death associated with concurrent utilization.
   c. (If applicable) I have informed the beneficiary about the risks of concomitant utilization of opioid and benzodiazepine therapy and the beneficiary expressed understanding of these risks.
   d. That the information provided is true and accurate to the best of the prescriber's knowledge.
   e. The prescriber understands that the Division of Medicaid (DOM) may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided
   f. Females of child-bearing age have been counseled on the risk of neonatal abstinence syndrome to the fetus

   Authorization will be issued for the requested duration (up to 90 days).

2. **For Patients Routinely Using Opioids**

   A routine opioid user is defined as having 1 opioid claim per month for the past 3 months prior to the current date of service.

   No PA criteria except for the following:

   a. Mississippi Medicaid's quantity limit (Max Unit Override PA)
   b. PDL Exception Request Criteria
   c. MEDD ≥ 90 MEDD Cumulative Threshold- criteria applies
   d. When a PA is approved for ≥ 90 MEDD, and the prescription's required quantity exceeds DOM's monthly quantity limit, the PA Unit shall issue an accompanying MAX Unit override PA.

Authorization will be issued for the requested duration (up to 180 days).

PRIOR AUTHORIZATION DESCRIPTION

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B. LONG-ACTING OPIOIDS

Long-Acting Opioids – Criteria for review of long acting opioid when there is no previous claim history of an opioid on file.

1. If the patient has moved to MS or has lost private insurance and is on Medicaid, the PA Unit shall contact the patient's pharmacy or provider for claims history to verify that patient is NOT opioid naïve. DOM assumes such measures are included in the existing transition of care plans for FFS and CAN beneficiaries.

    a. Pain is moderate to severe and expected to persist for an extended period of time
    b. Pain management is required around the clock with a long-acting opioid

    AND

2. Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days. (Document drug(s), dose, duration and date of trial), unless the patient is already receiving chronic opioid therapy prior to surgery for postoperative pain, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time.

Authorization will be issued for the requested duration (up to 180 days).

C. MORPHINE EQUIVALENT DAILY DOSE (MEDD) ≥ 90 MEDD Cumulative Threshold

Any prescriptions (whether individual and/or cumulative daily sum of all prescriptions for the patient) with a Morphine Equivalent Daily Dose (MEDD) of ≥ 90 will require a manual PA with documentation that the benefits outweigh the risks and that the patient has been counseled about the risks of overdose and death.*

1. Patients may receive opioid treatment for ≥90 MEDD in certain situations and the following are required:
    a. **Initial authorization** - the prescriber attests to all of the following:
        i. The information provided is true and accurate to the best of the prescriber's knowledge.
        ii. Opioid medication doses of <90 MEDD have been tried and did not adequately control pain (document drug regimen or MEDD and dates of therapy).
        iii. If patient exceeds 90MEDD it is recommended that Naloxone be co-prescribed due to increased risk of accidental death.

2. When a PA is approved for ≥ 90 MEDD, and the prescription's required quantity exceeds DOM's monthly quantity limit, the PA Unit shall issue an accompanying MAX Unit override PA
    b. **Reauthorization** – non-cancer/non-sickle cell disease-related pain and the prescriber attests to all of the following:
        i. Member demonstrates meaningful improvement in pain and function as documented in pain score improvement or increased function
        ii. (If applicable) Please provide tapering plan or justification for not tapering /discontinuing and
        iii. That the information provided is true and accurate to the best of the prescriber's knowledge.

Initial and reauthorization requests will be issued for the requested duration (up to 180 days).

PRIOR AUTHORIZATION DESCRIPTION

D. CONCOMITANT USE OF OPIOIDS AND BENZODIAZEPINES

Concomitant use of opioids and benzodiazepines should require a manual PA.

1. To allow for the short-term treatment of pre-procedure anxiety or other short-term anxiety, a prescription for up to 2 units of a solid oral dosage form of a benzodiazepine can be overridden at the point-of-sale by the dispensing pharmacist based upon his/her clinical judgment and consultation with the prescriber. A maximum of two, 2-unit prescriptions may be overridden in a 60 day period. Prospective DUR billing directions can be found on DOM's website.

2. Concomitant use of opioids and benzodiazepines is defined as a beneficiary having at least one day of concurrent therapy from both of the classes.
3. Patients may receive concomitant opioid and benzodiazepine therapy in certain situations:
    a. If patient is a chronic benzodiazepine user (defined as a history of one benzodiazepine claim per month for the past 3 months prior to the date of service) the prescriber shall provide a tapering plan or justification for not tapering /discontinuing and continuing concomitant use.
4. Prescribers must attest to the following:
    a. Concomitant opioid and benzodiazepine therapy is medically necessary.
    b. The prescriber has acknowledged that he/she has informed the beneficiary about the risks of concomitant utilization of opioid and benzodiazepine therapy or other drugs that could potentially cause respiratory depression and the beneficiary expressed understanding of these risks.

Authorization requests will be issued for the requested duration (up to 90 days).

CRITERIA/ADDITIONAL DOCUMENTATION
OPIOIDS

MISSISSIPPI DIVISION OF MEDICAID

BENEFICIARY INFORMATION	
Beneficiary ID:____ ____ ____ - ____ ____ ____ - ____ ____ ____	**DOB:____ ____ /____ ____ /____ ____ ____ ____**
Beneficiary Full Name:	

SECTION A: SHORT-ACTING OPIOIDS

Drug Name _____ Dosage Strength_____ Quantity_____

Length of Therapy_____ Total Daily Dose_____ Daily MEDD_____

Clinical justification for the use of opioid therapy greater than the day supply limit(s). Non-Preferred opioids must be accompanied by PDL Exception Request.

_____

_____

SECTION B: LONG-ACTING OPIOIDS

Drug Name _____ Dosage Strength_____ Quantity_____

Length of Therapy_____ Total Daily Dose_____ Daily MEDD_____

Clinical justification for the use of LA opioid therapy and attest that the patient has failed an adequate (minimum 2 week) trial of a SA opioid. Non-Preferred opioids must be accompanied by PDL Exception Request.

_____

_____

SECTION C: MORPHINE EQUIVALENT DAILY DOSE (MEDD) ≥ 90 MEDD Cumulative Threshold

Opioid #1_____ Dosage Strength_____ Quantity_____

Length of Therapy_____ Total Daily Dose_____ Total Daily MEDD _____

Opioid #2_____ Dosage Strength_____ Quantity_____

Length of Therapy_____ Total Daily Dose_____ Total Daily MEDD _____

If ≥90 MME, provide clinical rationale (tapering plan or justification for not tapering and discontinuing the opioid). _____

_____

_____

SECTION D: CONCOMITANT USE OF OPIOIDS AND BENZODIAZEPINES

Benzodiazepine Drug Name_____ Dosage Strength_____ Quantity_____

Day Supply_____ Length of Therapy_____ Total Daily Dose_____

Diagnosis / ICD-10 code(s) for Benzodiazepine therapy:_____
Please provide tapering plan or justification for not tapering /discontinuing and continuing concomitant use.

_____

_____

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CRITERIA/ADDITIONAL DOCUMENTATION
OPIOIDS

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PRESCRIBER ATTESTATION (CHECK ALL THAT APPLY)
☐ **The patient's history on the Prescription Monitoring Program (PMP) has been evaluated and continues to be evaluated on a regular basis.** ☐ **If applicable, I, the prescriber initiating or maintaining concomitant opioid and benzodiazepine therapy, acknowledge the risk of adverse events such as respiratory depression, coma, and death associated with concurrent utilization.** ☐**If applicable, I have informed the patient about the risks of concomitant utilization of opioid and benzodiazepine therapy or other drugs that could potentially cause respiratory depression and the patient expressed understanding of these risks.** ☐ **If applicable, I am aware that this drug is not FDA approved or has limitation for use due to the patient's age or medical condition and/or diagnosis.** ☐ **If applicable, for females of childbearing age, I have counseled the patient on the risks of becoming pregnant while receiving opioids, including the risk of neonatal abstinence syndrome.** By signing below, the prescriber certifies that the benefits of opioid treatment for this patient outweigh the risks and verifies that the information on this form is true and accurate to the best of my knowledge. **Prescriber Signature: _____ Date:_____/_____/_____** ***Prescribers should consider offering naloxone to beneficiaries with an increased risk of opioid overdose. Naloxone is covered in the Division of Medicaid's Universal Preferred Drug List (UPDL).***

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