

Prior Authorization Request Form – Long-Acting Narcotics

Instructions:

This form is to be used by providers to request coverage for Long-Acting Narcotic medications requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for urgent requests.

MedMetrics Health Partners – Prior Authorization Services Phone: 1-800-918-7550
 P. O. Box 2586, Worcester, MA 01606 Fax: 1-800-918-7542

A Long-Acting Narcotics step therapy program has been developed to encourage the use of first-line therapies before second-line therapies are used for the same indication. If approved, quantity limits apply.

<u>First-line therapies:</u> morphine ER <u>tablets</u> (MS Contin) methadone	<u>Second-line therapies:</u> fentanyl patch Oxycontin (oxycodone ER) Avinza morphine ER <u>capsules</u> (Kadian)	<u>Third-line therapies:</u> Exalgo Butrans patch
--	--	--

Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)
------------------------	----------------------------	-----------------------------

4. Prescriber's FULL Name & Specialty:	5. Contact Person at Office:
--	------------------------------

6. Prescriber's FAX & Telephone Number: Fax: ()	Tel: ()
Mailing Address:	

7. Requested Drug:	8. Dose, Frequency and Duration of Requested Drug:
--------------------	--

9. Has the member been started and stabilized on the requested drug (excluding samples)? <input type="checkbox"/> Yes <input type="checkbox"/> No - If 'yes', duration of therapy = _____
--

10. Diagnosis and Indication for Use: _____ _____
<ul style="list-style-type: none"> • Please indicate if the pain is moderate-to-severe in nature: <input type="checkbox"/> Yes <input type="checkbox"/> No • Please indicate if the medication is being used for the following? <input type="checkbox"/> Around-the clock analgesia <input type="checkbox"/> PRN basis • Please indicate if being used to treat an end-stage, terminal illness: <input type="checkbox"/> Yes <input type="checkbox"/> No

11. Has the member previously tried morphine ER tablets? <input type="checkbox"/> Yes <input type="checkbox"/> No - If 'yes', what was the outcome of the trial? <input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
Please list all other narcotic agents tried for this current condition and the corresponding outcome(s):
Drug: _____ Outcome: _____
Drug: _____ Outcome: _____
Drug: _____ Outcome: _____

12. Does the member have a documented swallowing disorder or inability to swallow oral medications? <input type="checkbox"/> Yes <input type="checkbox"/> No - If 'yes', please specify: _____

13. Prescriber comments:

Signature:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

 Prescriber's signature

 Date