Kepro

Prior Authorization Vendor for ND Medicaid

Opioid Analgesics
Prior Authorization Form

Fax completed form to:
855-207-0250
For questions regarding this prior authorization, call
866-773-0695

*** Please see criteria for coverage under "Opioid Analgesics" in the Preferred Drug List at**
www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER REPRESENTATIVE

Member Name	Member Date of Birth	Member Medicaid ID Number
Prescriber Name	Pain, Palliative Care, or Oncology/Hematology Specialist involved in therapy (if not treating prescriber):	
Prescriber NPI	Telephone Number	Fax Number
Requested Opioid Analgesic:	**Diagnosis for use of opioid(s) in this member:**	

List All Failed/Current Medications:	**Dose and Frequency:**	**Start/End Date:**	**Reason for failure:**
☐ NSAIDs ☐ TCAs ☐ SNRIs ☐ Corticosteroids ☐ Weight Loss ☐ Physical Therapy ☐ Cognitive Behavioral Therapy ☐ Other:_____			

Qualifications for coverage:

1. Have the past 3 months of North Dakota PDMP reports been reviewed by the prescriber? ☐ YES ☐ NO
2. Does the member have access to an opioid reversal medication and has been counseled on overdose risk? ☐ YES ☐ NO
3. Does the member reside in a facility with skilled nursing care? ☐ YES ☐ NO
4. Has the provider established a realistic treatment plan with the member, including goals for pain and function, and urine and/or blood screens? ☐ YES ☐ NO
5. Is the member established on opioids from a recent hospitalization? ☐ YES ☐ NO
6. Does this request include an opioid taper plan? ☐ YES ☐ NO
7. Is the member currently on a long-acting opioid therapy? ☐ YES ☐ NO
   a. If yes, please provide drug name, dose, and frequency: _____

For fentanyl patch requests only:

1. What is the member's BMI?: _____

These questions are only required for members that have not been on 30 MME for at least a week:

1. What is the member's pain level (0-10)?: _____
2. Is the member able to swallow? ☐ YES ☐ NO

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #