health information designs

Opioid Analgesics
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a long-acting opioid analgesic must meet the following criteria:

- Patient must have required around-the-clock pain relief for the past 90 days
- The past 3 months of North Dakota PDMP reports must have been reviewed by the prescriber.
- Patient must be in consult with oncologist or pain management specialist with a pain management contract (with treatment plan including goals for pain and function, and urine and/or blood screens) if:
  - Cumulative daily dose of narcotics exceed 90 MED/day
  - Patient is using benzodiazepine concurrently with narcotic medication
- Patient must have not achieved therapeutic goal with non-narcotic medication (NSAIDs, TCAs, SNRIs, Corticosteroids, etc.) and non-medication alternatives (Weight Loss, Physical Therapy, Cognitive Behavioral Therapy, etc.)

*** For additional and agent-specific criteria, please see criteria for coverage in the Preferred Drug List at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf**

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Pain, Palliative Care, or Oncology/Hematology Specialist involved in therapy (if not treating physician):		
Prescriber NPI	Telephone Number	Fax Number	
Requested Opioid Analgesic:	**Diagnosis for use of opioid(s) in this patient:**		
List All Failed/Current Medications: □ NSAIDs □ TCAs □ SNRIs □ Corticosteroids □ Weight Loss □ Physical Therapy □ Cognitive Behavioral Therapy □ Other:	**Dose and Frequency:**	**Start/End Date:**	**Reason for failure:**

Qualifications for coverage:	
Has the past 3 months of North Dakota PDMP reports must have been reviewed by the prescriber?	□ YES □ NO
Has the provider established a realistic treatment plan with the patient, addressing expected outcomes and limitations of therapy in totally eliminating pain?	□ YES □ NO
Does the patient undergo routine drug screens?	□ YES □ NO

Please confirm that all the following is attached to the request, along with any other relevant documentation:

□ Patient's treatment plan including an evaluation of effectiveness and plans for continuation/discontinuation
□ Clinical documentation of previously tried and failed non-opioid therapies.

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 patient'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.*