



**Benzodiazepine + Opioid Concurrent Use
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 both an opioid analgesic and a benzodiazepine must meet the following criteria:

- Patient must have tried all treatment alternatives without achievement of therapeutic goal (please provide details on trial and outcome, or reason alternative cannot be attempted)
- Either a tapering plan must be included, or given the CDC guidelines and FDA black box warnings, clinical justification must be provided to explain:
 - o Reason opioid analgesic cannot be avoided in this patient currently receiving a benzodiazepine
 - o Reason the patient cannot use lower dose opioid treatment

Part I: TO BE COMPLETED BY PRESCRIBER OF THE OPIOID ANALGESIC

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:	
Plan to taper: (dose and length of treatment)	Clinical justification for concurrent opioid and benzodiazepine treatment and/or reason opioid dose cannot be reduced:	
Treatment Alternatives: <input type="checkbox"/> NSAIDs <input type="checkbox"/> TCAs <input type="checkbox"/> SNRIs <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Weight Loss <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Cognitive Behavioral Therapy <input type="checkbox"/> Other	Start/End Date:	Reason for failure:
Qualifications for coverage:		
Does provider routinely check the PDMP?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the provider established a realistic treatment plan with the patient, addressing expected outcomes and limitations of therapy in totally eliminating pain?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Will opioid therapy be routinely evaluated for effectiveness?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the patient undergo routine drug screens?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the provider discussed and counseled the patient on the known risks of utilizing opioid analgesics in combination with benzodiazepines and other CNS depressing medications/conditions?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Please confirm that all the following is attached to the request, along with any other relevant documentation:		
<input type="checkbox"/> Patient's treatment/tapering plan including an evaluation of effectiveness and plans for continuation/discontinuation <input type="checkbox"/> 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 recoument.*



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- Patient must have tried all treatment alternatives without achievement of therapeutic goal (please provide details on trial and outcome, or reason alternative cannot be attempted)
- Either a tapering plan must be included, or given the CDC guidelines and FDA black box warnings, clinical justification must be provided to explain:
 - o Reason opioid analgesic cannot be avoided in this patient currently receiving a benzodiazepine
 - o Reason the patient cannot use lower dose opioid treatment

Part I: TO BE COMPLETED BY PRESCRIBER OF THE BENZODIAZEPINE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating physician)	
Prescriber NPI	Telephone Number	Fax Number
Requested Benzodiazepine:	Diagnosis for use of a benzodiazepine in this patient:	
Plan to taper: (dose and length of treatment)	Clinical justification for concurrent opioid and benzodiazepine treatment and/or reason opioid dose cannot be reduced:	
List all failed treatments: <input type="checkbox"/> SSRIs <input type="checkbox"/> SNRIs <input type="checkbox"/> Buspirone <input type="checkbox"/> Lyrica <input type="checkbox"/> Mirtazapine <input type="checkbox"/> Exercise Therapy <input type="checkbox"/> Cognitive Behavioral Therapy <input type="checkbox"/> Relaxation and Breath Training <input type="checkbox"/> Other	Start/End Date:	Reason for failure:
Qualifications for coverage:		
Does provider routinely check the PDMP?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the provider established an appropriate treatment plan with the patient, addressing the delayed onset of effectiveness of their maintenance therapy?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Will the benzodiazepine therapy be routinely evaluated for continued necessity?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Does the patient undergo routine drug screens?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Has the provider discussed and counseled the patient on the known risks of utilizing benzodiazepines in combination with opioid analgesics and other CNS depressing medications/conditions?		<input type="checkbox"/> YES <input type="checkbox"/> NO
Please confirm that all of the following is attached to the request, along with any other relevant documentation:		
<input type="checkbox"/> Patient's treatment plan including an evaluation of effectiveness and plans for continuation/discontinuation <input type="checkbox"/> Clinical documentation of previously tried and failed non-benzodiazepine therapies.		
Prescriber (or Staff) / Pharmacy Signature**		Date