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 Medicaid

ND Medicaid requires that members receiving both an opioid analgesic and a benzodiazepine must meet the following criteria:

- Member 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:
  - Reason opioid analgesic cannot be avoided in this member currently receiving a benzodiazepine
  - Reason the member cannot use lower dose opioid treatment

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

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:**	
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: ☐ NSAIDs ☐ TCAs ☐ SNRIs ☐ Corticosteroids ☐ Weight Loss ☐ Physical Therapy ☐ Cognitive Behavioral Therapy ☐ Other	**Start/End Date:**	**Reason for failure:**

Qualifications for coverage:	
Does provider routinely check the PDMP?	☐ YES ☐ NO
Has the provider established a realistic treatment plan with the member, addressing expected outcomes and limitations of therapy in totally eliminating pain?	☐ YES ☐ NO
Will opioid therapy be routinely evaluated for effectiveness?	☐ YES ☐ NO
Does the member undergo routine drug screens?	☐ YES ☐ NO
Has the provider discussed and counseled the member on the known risks of utilizing opioid analgesics in combination with benzodiazepines and other CNS depressing medications/conditions?	☐ YES ☐NO

Please confirm that all the following is attached to the request, along with any other relevant documentation:
☐ Member's treatment/tapering 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 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.*

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- Member 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:
  - Reason opioid analgesic cannot be avoided in this member currently receiving a benzodiazepine
  - Reason the member cannot use lower dose opioid treatment

Part I: TO BE COMPLETED BY PRESCRIBER REPRESENTATIVE OF THE BENZODIAZEPINE

Member Name	Member Date of Birth	Member Medicaid ID Number
Prescriber Name	Specialist involved in therapy (if not treating prescriber)	
Prescriber NPI	Telephone Number	Fax Number
Requested Benzodiazepine:	**Diagnosis for use of a benzodiazepine in this member:**	
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: ☐ SSRIs ☐ SNRIs ☐ Buspirone ☐ Lyrica ☐ Mirtazapine ☐ Exercise Therapy ☐ Cognitive Behavioral Therapy ☐ Relaxation and Breath Training ☐ Other	**Start/End Date:**	**Reason for failure:**

Qualifications for coverage:	
Does provider routinely check the PDMP?	☐ YES ☐ NO
Has the provider established an appropriate treatment plan with the member, addressing the delayed onset of effectiveness of their maintenance therapy?	☐ YES ☐ NO
Will the benzodiazepine therapy be routinely evaluated for continued necessity?	☐ YES ☐ NO
Does the member undergo routine drug screens?	☐ YES ☐ NO
Has the provider discussed and counseled the member on the known risks of utilizing benzodiazepines in combination with opioid analgesics and other CNS depressing medications/conditions?	☐ YES ☐ NO

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

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

Prescriber (or Staff) / Pharmacy Signature**	Date