Acentra HEALTH

Prior Authorization Vendor for ND Medicaid

Benzodiazepine + Opioid Concurrent Use Prior Authorization Form

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

ND Medicaid requires that members receiving both an opioid analgesic and a benzodiazepine to meet specific clinical criteria for coverage which can be found at https://ndmedicaid.acentra.com/ndpdl/

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 (only applicable if criteria requires)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
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:			

List all failed treatments:	**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 discussed and counseled the member on the known risks of utilizing opioids and benzodiazepines in combination with each other and other CNS depressing medications, including antipsychotics and sedatives? ☐ YES ☐ NO
5. Is the member currently on a long-acting opioid therapy? ☐ YES ☐ NO
6. *For requests over 90 MME/day:* Has the provider established a realistic treatment plan with the member, addressing the delayed onset of effectiveness of their maintenance therapy, goals for pain and function, and urine and/or blood screens? ☐ 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.*

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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 (only applicable if criteria requires)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
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:	**Start/End Date:**	**Reason for failure:**
☐ SSRIs ☐ SNRIs ☐ Buspirone ☐ Lyrica ☐ Mirtazapine ☐ Exercise Therapy ☐ Cognitive Behavioral Therapy ☐ Relaxation and Breath Training ☐ 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 reside in a facility with skilled nursing care? ☐ YES ☐ NO
3. Has the provider discussed and counseled the member on the known risks of utilizing opioids and benzodiazepines in combination with each other and other CNS depressing medications, including antipsychotics and sedatives? ☐ 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.*