VERMONT
Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~Long Acting Opioid~
Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare help desk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:

Name: _____
Physician NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:

Name: _____
Medicaid ID#: _____
Date of Birth: _____ Sex: _____
Pharmacy Name_____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

1. Opioid Regimen: Please include drug(s) requested, strength, route, frequency, and duration of use:
   _____
   _____

2. Diagnosis or Indication for Use:
   _____

3. Has the member previously tried any of the following preferred medications?

Check all that apply:	***Response, check all that apply***
☐ Fentanyl Patches	☐ side-effect ☐ non-response ☐allergy
☐ Morphine Sulfate CR 12 Hr Tablet	☐ side-effect ☐ non-response ☐allergy
☐ Xtampza® ER (oxycodone ER) Capsule	☐ side-effect ☐ non-response ☐allergy

For tramadol products, has the member previously tried the following preferred medication?

Check if applicable:	***Response, check all that apply:***
☐ Tramadol immediate release	☐ side-effect ☐ non-response ☐allergy

Is this an initial request or a renewal request? ☐ Initial ☐ Renewal

****The following OPIOID SAFETY CHECKLIST must be completed for new patients with a cumulative daily MME > 90 per day, or > 120 MME per day for existing patients as of 5/1/21 (applies to any combination of short and/or long-acting opiates)****

Does the patient reside in a nursing home?	YES	NO
Is the patient receiving or eligible for hospice services?	YES	NO
Is the patient's chronic pain associated with cancer or cancer treatment?	YES	NO
IF YES TO ONE OF THE ABOVE QUESTIONS, MAY PROCEED TO SIGNATURE AND DATE		

Non-Opioid alternatives (up to a maximum dose recommended by the FDA) have been considered, and any appropriate treatments are documented in the patient's medical records. Such treatments may include, but are not limited to: NSAIDs, Acetaminophen.	YES	NO
Non-Pharmacological Treatments have been considered, and any appropriate treatments are documented in the patient's medical records. Such treatments may include, but are not limited to: Acupuncture, Chiropractic, Physical Therapy.	YES	NO
Vermont Prescription Monitoring System (VPMS) has been queried.	YES	NO
Patient education and informed consent have been obtained, and a Controlled Substance Treatment Agreement is included in the patient's medical record.	YES	NO
A reevaluation of the effectiveness and safety of the patient's pain management plan, including an assessment of the patient's adherence to the treatment regimen is completed no less than once every 90 days.	YES	NO
Patient has a valid prescription for or states they are in possession of naloxone.	YES	NO

Other Information/ Comments: _____

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/or recoupment.

Prescriber's Signature: _____ **Date:** _____

CHANGE HEALTHCARE