Magellan COMPLETE CARE®

MAGELLAN COMPLETE CARE OF VIRGINIA – CCC PLUS
Service Authorization (SA) Form
SHORT- AND LONG-ACTING OPIOIDS

If the following information is not complete, correct or legible, the SA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

This REQUEST is for: ☐ **Short-Acting Opioid** ☐ **Long-Acting Opioid** ☐ **BOTH (check all that apply)**

Service Authorization is required for:

1. All Long-Acting Opioids
2. Any Short-Acting Opioid prescribed for > 7 days or two 7-day supplies in a 60-day period. The Virginia BOM Regulations limit the treatment of acute pain with opioids to 7 days.
3. Any cumulative opioid prescription exceeding 90 morphine milligram equivalents (MME) per day. Quantity limits apply to each drug.

Long-Acting Opioids (LAOs): LAOs are indicated for members with chronic, moderate to severe pain who require daily, around-the-clock opioid treatment and require a SA. Consider non-pharmacologic and non-opioid pain treatments prior to treatment with opioids. Members should be considered for buprenorphine analgesic treatment with either topical patch since this product has a ceiling effect with less risk of respiratory depression than other opioids.

https://www.virginiamedicaidpharmacyservices.com/provider/external/medicaid/vamps/doc/en-us/VAMPS_Short_and_Long_Acting_Opioid_Daily_Dose_Limit.pdf

(Form continued on next page.)

 Revised: 02/20/2020 | Effective: 01/01/2020

Member's Last Name:

Member's First Name:

Preferred Long-Acting Opioids (Sch III-VI)	Butrans® Transdermal Patch	
Preferred Long-Acting Opioids (Sch II)	Fentanyl 12, 25, 50, 75 & 100 mcg patches Morphine sulfate ER tab	
Preferred Short-Acting Opioids	Codeine/APAP Hydrocodone/APAP Hydrocodone/ibuprofen Hydromorphone Morphine IR	Oxycodone IR Oxycodone/APAP Tramadol HCl Tramadol HCl/APAP

Drug 1	Drug 2
Drug Name/Form:	**Drug Name/Form:**
Strength:	**Strength:**
Dosing Frequency:	**Dosing Frequency:**
Length of Therapy:	**Length of Therapy:**
Quantity per Day:	**Quantity per Day:**

Alternative Therapy to Schedule II Opioids. Based on the Virginia Board of Medicine's Opioid Prescribing Regulations, Opioids are NOT recommended as first line treatment for acute or chronic pain. For additional information, please see VA Board of Medicine Regulations: http://www.dhp.virginia.gov/medicine/

Preferred Pain Relievers available without SA include NSAIDS topical and oral, SNRIs, Tricyclic Antidepressants, Gabapentin, Baclofen, Capsaicin topical cream 0.025%, Lidocaine 5% Patch and Pregabalin (Lyrica®). Consider alternative therapies to Schedule II opioid drugs due to their high potential for abuse and misuse. A complete list of covered drugs can be found at:
https://www.virginiamedicaidpharmacyservices.com/documents/VAmed-PDL-List-Criteria.

(Form continued on next page.)

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Member's First Name:

TREATMENT INFORMATION

PA Criteria Align with Virginia Board of Medicine's Regulations Governing Prescribing of Opioids and Buprenorphine: http://www.dhp.virginia.gov/medicine/

Length of Authorization: 3 months based on the following diagnosis (please check all that apply):

- ☐ HIV/AIDS
- ☐ Chronic back pain
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Diabetic neuropathy
- ☐ Postherpetic Neuralgia
- ☐ Other:_____

Length of Authorization: 6 months based on the following diagnosis (please check all that apply):

- ☐ Cancer pain
- ☐ Sickle cell disease
- ☐ Palliative care
- ☐ End-of-Life Care
- ☐ Hospice patient

1. Does prescriber attest that the member has intractable pain associated with active cancer, palliative care (treatment of symptoms associated with life limiting illnesses), or hospice care? (IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless a non-preferred/non-formulary drug is prescribed. See Q6 if non-formulary drug is prescribed.)
   ☐ Yes ☐ No
2. Is member in remission from cancer and prescriber is safely weaning member off opioids with a tapering plan? (IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless a non-preferred/ non-formulary drug is prescribed. See Q6 if non-formulary drug is prescribed.)
   ☐ Yes ☐ No
3. Is member in a long-term care facility? (IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless a non-preferred/non-formulary drug is prescribed. See Q6 if non-formulary drug is prescribed.)
   ☐ Yes ☐ No
4. Please indicate if the member has tried and failed any of the following therapies covered without SA *(select all that apply):*
   - ☐ Baclofen
   - ☐ Capsaicin Gel
   - ☐ Duloxetine
   - ☐ Gabapentin
   - ☐ Lidocaine 5% Patch
   - ☐ NSAIDs (oral)
   - ☐ Physical Therapy
   - ☐ Tricyclic Antidepressant (e.g., nortriptyline)
   - ☐ Cognitive behavioral therapy (CBT)
   - ☐ Other: _____

(Form continued on next page.)

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Member's First Name: | | | | | | | | | | | | |

5. If requesting a non-preferred product (i.e., Avinza®, Kadian®, Embeda®), has the member tried and failed an adequate trial of 2 different preferred products?

   ☐ Yes ☐ No

   If YES, please list drug name, length of trial, and reason for discontinuation.

   _____

6. Provide the member's Active Daily Morphine Milligram Equivalents (MME) from the Prescription Monitoring Program (PMP) (https://virginia.pmpaware.net/login)

   MME: _____

   a. If member's Active Daily MME greater than or equal to 90, does the prescriber attest that he/she will be managing the member's opioid therapy long term, has reviewed the Virginia BOM Regulations for Opioid Prescribing, has prescribed naloxone, and acknowledges the warnings associated with high dose opioid therapy including fatal overdose, and that therapy is medically necessary for this member?

      ☐ Yes ☐ No

7. Provide member's last fill date of Opioid prescription from the PMP: _____

   ☐ N/A

8. Provide member's last fill date of benzodiazepine prescription from the PMP: _____

   a. If benzodiazepine filled in past 30 days, does the prescriber attest that he/she has counseled the member on the FDA black box warning on the dangers of prescribing opioids and benzodiazepines including fatal overdose, has documented that the therapy is medically necessary, and has recorded a tapering plan to achieve the lowest possible effective doses of both opioids and benzodiazepines per the Board of Medicine Opioid Prescribing Regulations?

      ☐ Yes ☐ No ☐ N/A

9. Has naloxone been prescribed for members with risk factors of overdose? Risk factors for overdose include substance use disorder, doses in excess of 50 MME/day, antihistamines, antipsychotics, benzodiazepines, gabapentin, pregabalin, tricyclic antidepressants, or the "Z" drugs (zopiclone, zolpidem, or zaleplon).

   ☐ Yes ☐ No

10. If member is female between 18-45 years old, has the prescriber discussed risk of neonatal abstinence syndrome and provided counseling on contraceptive options?

    ☐ Yes ☐ No

(Form continued on next page.)

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11. Prescriber attests that a treatment plan with goals that addresses benefits and harm has been established with the patient.

☐ Yes ☐ No

If NO, please explain:

_____

_____

_____

12. For chronic pain, has the prescriber ordered and reviewed a urine drug screen (UDS) or serum medication level prior to initiating treatment with short or long-acting opioids?

☐ Yes ☐ No ☐ N/A

13. For SA renewals, has the prescriber ordered and reviewed a urine drug screen (UDS) or serum medication level at least every 3 months for the first year of treatment and at least every 6 months thereafter to ensure adherence?

☐ Yes ☐ No ☐ N/A

_____ _____

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be faxed to **1-800-922-3986,** phoned to **1-800-424-4524 (TTY 711)** or mailed to:

Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
11013 West Broad Street
Glen Allen, VA 23060

Magellan Complete Care of Virginia website: www.mccofva.com

 Revised: 02/20/2020 | Effective: 01/01/2020