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PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 9/21/17**
SECTION: DRUGS	**LAST REVIEW DATE: 9/20/18**
	LAST CRITERIA REVISION DATE: 9/20/18
	ARCHIVE DATE:

XTAMPZA ER™ (oxycodone) extended-release oral capsule

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

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Criteria:

- **Criteria for initial therapy:** Xtampza ER is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Individual is 18 years of age or older

2. A confirmed diagnosis of **ONE** of the following:
   - cancer related pain
   - pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options like **Short Acting Narcotics**, **non-opioid therapy** are ineffective, not tolerated, or inadequate

3. Failure, contraindication, or intolerance to **ALL** the following:
   - Morphine Extended Release
   - Embeda ER capsule
   - Nucynta ER tablet
   - Oxycodone ER tablet
   - Fentanyl transdermal

4. Coordination of care will be performed between different prescribers for **ALL** controlled substances

5. **For non-cancer pain**: For **morphine equivalent dosing (MED) greater than 180mg/day**:
   - A dosing schedule to bring individual to a lower dosage of MED less than 180mg/day (titration schedule required)

6. **For non-cancer pain**: A **treatment plan,** including:
   - Pain intensity (scales or ratings)
   - Functional status (physical and psychosocial)
   - Patient's goal of therapy (level of pain acceptable and/or functional status)
   - Current non-pharmacological treatment

7. **For non-cancer pain**: Physician-patient **pain management contract** must be provided

8. **For non-cancer pain**: Documentation must be included for **random urine or blood tests** twice a year

9. **For non-cancer pain**: Documentation of **PDMP reviewed** by the prescriber every time a prescription for controlled substance is provided

10. **For non-cancer pain**: **One pharmacy (and another 24-hour closest pharmacy)** must be selected for all the controlled substances prescription services (limitation may vary by specific member's benefit plan*)

11. **For non-cancer pain**: Individual has been evaluated and must **not** have an active addiction to illicit substances or prescription drugs or a drug seeking behavior

12. There is **NO** concomitant use with benzodiazepines-ex. clonazepam, lorazepam, diazepam etc. **OR** treatment plan to taper use and coordinate care

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13. Absence of **ALL** contraindications
    - Contraindications include:
      - Significant respiratory depression
      - Acute or severe bronchial asthma
      - Known or suspected gastrointestinal obstruction, including paralytic ileus
      - Hypersensitivity to oxycodone

Initial approval duration:
- Xtampza ER will be approved at the requested dosage for 6 months for pain not related to cancer
- Xtampza ER will be approved at the requested dosage for 12 months for pain related to cancer
- For non-cancer pain, one pharmacy (and another 24-hour closest pharmacy) must be selected for all the controlled substances prescription services (limitation may vary by specific member's benefit plan*)

➢ **Criteria for continuation of coverage (renewal request):** Xtampza ER is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

1. Individual's pain is controlled with these products
2. Continued coordination of care between different prescribers for **ALL** controlled substances
3. The condition has not progressed or worsened while on therapy and no development of severe side effects like:
   - Apnea, dyspnea, epistaxis, hemoptysis, hyperventilation, hypoxia, upper respiratory infection etc.
   - Confusion/speech disturbance
   - Dehydration
   - Atrial fibrillation/arrhythmia/chest pain
   - Ascites
4. **For non-cancer pain**: A **treatment plan**, including:
   - Pain intensity (scales or ratings)
   - Functional status (physical and psychosocial)
   - Patient's goal of therapy (level of pain acceptable and/or functional status)
   - Current non-pharmacological treatment
5. **For non-cancer pain**: Physician-patient **pain management contract** must be provided
6. **For non-cancer pain**: Documentation must be included for **random urine or blood tests** twice a year
7. **For non-cancer pain**: Documentation of **PDMP reviewed** by the prescriber every time a prescription for controlled substance is provided
8. **For non-cancer pain**: **One pharmacy (and another 24-hour closest pharmacy)** must be selected for all the controlled substances prescription services (limitation may vary by specific member's benefit plan*)

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9. **For non-cancer pain**: Individual has been evaluated and must **not** have an active addiction to illicit substances or prescription drugs or a drug seeking behavior

10. There is **NO** concomitant use with benzodiazepines-ex. clonazepam, lorazepam, diazepam etc. **OR** treatment plan to taper use and coordinate care

Renewal duration:
- Xtampza ER will be approved at the requested dosage for 12 months for pain not related to cancer
- Xtampza ER will be approved at the requested dosage for 12 months for pain related to cancer
- For non-cancer pain, one pharmacy (and another 24-hour closest pharmacy) must be selected for all the controlled substances prescription services (limitation may vary by specific member's benefit plan*)

*For Qualified Health Plans (**QHP**) for Individuals/Families and Small Groups:
"Narcotics Designated Network Program" is a program that requires certain members taking narcotic medications to obtain prescriptions for all covered narcotic medications from one designated eligible physician or other provider and to obtain all covered narcotic medications from one network pharmacy designated by BCBSAZ and/or the PBM.

- **Patients should be tapered off or lower the dosage if any of the following apply: See "Definitions" section for Tapering guidelines**
  - The patient has committed serious or repeated drug seeking behavior
  - The patient makes no progress toward therapeutic goals

- **For all patients receiving more than 200 mg morphine or equivalent per 24 hours: See "Definitions" section for Tapering guidelines**
  - Taper patient to a lower dosage
  - Provide a Naloxone prescription to avoid side effects
  - Initiate/augment non-opioid treatments
  - Provide BH/Case management support to help with the taper

Description:

INTRODUCTION - Chronic pain is among the most common reasons for seeking medical attention and is reported by 20 to 50 percent of patients seen in primary care. A number of pharmacologic and nonpharmacologic therapies are available for patients with chronic pain. An overview of these treatments is presented here.

COMMON CAUSES OF CHRONIC PAIN - Although pain is one of the most common presenting symptoms to the primary care clinician, only a percentage of patients ultimately develop a chronic pain syndrome. In a study based on a survey of representative population in the United States from 1999 to 2002 (the National Health and Nutrition Examination Survey, NHANES), chronic pain (defined as >three months of pain) was reported as follows: back pain 10.1 percent, leg/foot pain 7.1 percent, arm/hand pain 4.1 percent, headache 3.5 percent, chronic regional pain 11.1 percent, widespread pain 3.6 percent; the majority of patients who reported chronic pain reported more than one type of pain.

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Chronic pain can be considered to be in one of four categories. Identifying which of these categories the patient falls into is helpful in designing an appropriate treatment plan, although multifactorial causes of chronic pain are not uncommon. These pain categories can be considered to be:

- Neuropathic pain (either peripheral, including post-herpetic neuralgia, diabetic neuropathy; or central, including post-stroke pain or multiple sclerosis)
- Musculoskeletal pain (eg, back pain, myofascial pain syndrome, ankle pain)
- Inflammatory pain (eg, inflammatory arthropathies, infection)
- Mechanical/compressive pain (eg, renal calculi, visceral pain from expanding tumor masses)

APPROACH TO THE PATIENT - Treatment options for chronic pain generally fall into six major categories: pharmacologic, physical medicine, behavioral medicine, neuromodulation, interventional, and surgical approaches. Optimal patient outcomes often result from multiple approaches utilized in concert, coordinated via a multidisciplinary team. Collaborative care models in primary care can improve pain management and patient outcomes. Medication should not be the sole focus of treatment, but should be used when needed, in conjunction with other treatment modalities, to meet treatment goals.

Patients with chronic pain require ongoing evaluation, education and reassurance, as well as help in setting reasonable expectations for response. Currently available treatment modalities on average result in only about a 30 percent decrease in pain. But even a partial response of 30 percent can be clinically significant and improve the patient's quality of life.

PHARMACOLOGIC OPTIONS - Pharmacologic approaches are the most widely used therapeutic options to ameliorate persistent pain. The major categories of pharmacologic agents for pain management include nonopioid analgesic medications, opioids and adjuvants (used to treat the side effects associated with pain medications or potentiate analgesia):

- Nonopioid analgesic agents (eg, aspirin, acetaminophen, nonsteroidal anti-inflammatory drugs [NSAIDs], COX-2 Inhibitors)
- Tramadol
- Opioids
- Alpha 2 adrenergic agonists
- Antidepressants (tricyclics and serotonin-norepinephrine reuptake inhibitors [SNRIs])
- Antiepileptic drugs (gabapentin, pregabalin, and other anticonvulsants)
- Muscle relaxants
- N-methyl-d-aspartate (NMDA) receptor antagonists
- Topical analgesic agents

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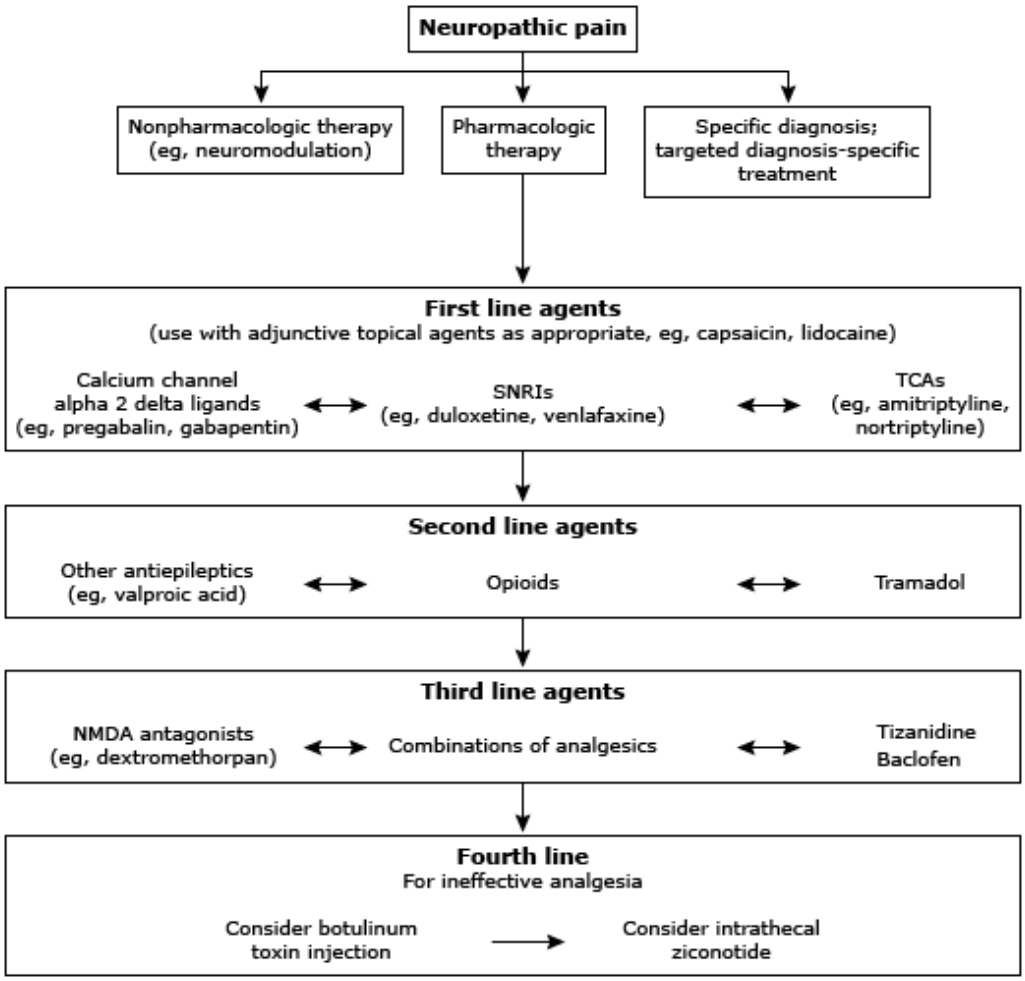
Neuropathic pain: Pharmacologic approach



- Optimal patient outcomes for chronic pain often result from multiple approaches (pharmacologic, physical medicine, behavioral medicine, neuromodulation, and interventional approaches) utilized in concert, coordinated via a multidisciplinary team of pain specialists. Medication should not be the sole focus of treatment but should be used when needed, in conjunction with other treatment modalities, to meet treatment goals.

- The choice of an appropriate initial therapeutic strategy is dependent upon an accurate evaluation of the cause of the pain and the type of chronic pain syndrome. In particular, neuropathic pain should be distinguished from nociceptive pain. For most patients, the initial treatment of neuropathic pain involves either antidepressants (tricyclic antidepressants or dual reuptake inhibitors of serotonin and norepinephrine) or calcium channel alpha 2-delta ligands (gabapentin and pregabalin), with adjunctive topical therapy when pain is localized. Opioid medications and tramadol are second-line agents for most

patients with neuropathic pain. In contrast, the pharmacologic approach to nociceptive pain primarily involves nonnarcotic and opioid analgesia.

- Nonopioid analgesics include acetaminophen, "traditional" nonselective nonsteroidal anti-inflammatory drugs (NSAIDs), and cyclooxygenase 2 (COX-2) inhibitors.
  Acetaminophen is not as effective as NSAIDs for the treatment of knee and hip pain related to osteoarthritis and may cause hepatic damage in patients with underlying liver disease or at higher doses. NSAIDs should be avoided in older adults when possible.

- Gabapentin is effective for the treatment of postherpetic neuralgia and painful diabetic neuropathy. Pregabalin may provide analgesia more quickly than gabapentin but has been associated with euphoria and is a Schedule V controlled substance.

- Both tricyclic antidepressants (TCAs) and serotonin norepinephrine reuptake inhibitors (SNRIs) possess analgesic qualities while the evidence for the effectiveness of selective serotonin reuptake inhibitors (SSRIs) is weaker.

- The role of opioid therapy in the more severe forms of acute pain and in cancer pain is well established, but opioid administration in chronic noncancer pain remains controversial.

Xtampza ER (oxycodone extended release) is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. It should be reserved for use in patients for whom alternative treatment options (such as non-opioid analgesics or immediate release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. Xtampza ER (oxycodone extended release) is not indicated as an as needed (prn) analgesic.

Opioid analgesic medications relieve a wide variety of pain syndromes and are generally accepted for the treatment of severe acute pain and chronic pain related to active cancer. In contrast, the use of chronic opioid therapy to treat other types of chronic pain not associated with malignancy remains controversial. There is a large amount of clinical experience with opioids for the treatment numerous pain syndromes, yet there are limited data on the safety and efficacy of long-term opioid therapy for chronic non-cancer pain.

There are many agents available with brand and generic options for the treatment of pain. Several agents are also available as both immediate- (or short-) acting and long-acting formulations. There are clinically meaningful differences in potency, time to onset, elimination and duration of action among the various compounds.

Long-acting opioids are more convenient than short-acting opioids for the treatment of chronic pain conditions, although there is no reliable evidence of their superiority. There is no reliable comparative evidence demonstrating that one long-acting opioid is more effective than another opioid analgesic, including immediate-acting or other long-acting formulations.

Specific central nervous system (CNS) opiate receptors and endogenous compounds with morphine-like activity have been identified throughout the brain and spinal cord and are likely to play a role in the expression and perception of pain. Opioid receptors have also been identified within the peripheral nervous system (PNS). The primary site of therapeutic action of opioids is within the CNS. Opioid agonists are thought to reduce pain by

XTAMPZA ER™ (oxycodone) extended-release oral capsule (cont.)

acting primarily through interaction with opioid mu-receptors located in the brain, spinal cord, and smooth muscle. Opioid agonists produce respiratory depression by direct action on the brain stem respiratory center.

All opioids have the potential to cause respiratory depression, abuse and physical dependence. None have been proven to be safer than another. One method employed by manufacturers to mitigate abuse of opioids has been formulating products that are difficult to extract the main opioid ingredient from the original form. No opioid formulation or reformulation prevents use of large dosage units which is the most common method of abuse. There is concern that use of abuse deterrent formulations may shift use to other opioids, including heroin.

Providers should individualize treatment of pain in every case, using non-opioid analgesics, opioids on an as needed basis, combination products, and when appropriate chronic opioid therapy in a progressive comprehensive plan of pain management.

The World Health Organization's (WHO) guidelines for cancer pain management recommends a three-stepped approach with consideration for the type of pain and response to therapy. Initial therapy includes non-opioid analgesics such as non-steroidal anti-inflammatory drugs (NSAIDs). For mild to moderate pain, oral combinations of acetaminophen and NSAIDs with opioids are recommended. For moderate to severe pain, opioid analgesics are recommended. Titration of dose and frequency is individualized to the patient's response and development of adverse effects. For patients with inadequate pain relief and intolerable opioid-related toxicity/adverse effects, a switch to an alternative opioid may be an option for obtaining symptomatic relief.

The National Comprehensive Cancer Network (NCCN) 2015 Clinical Practice Guideline in Oncology: Adult Cancer Pain outlines numerous steps in managing opioid medications in cancer pain that can be adapted for non-cancer pain management. Examples of some of the recommendations include: use short-acting opioid medications for titration, for persistent pain initiate regular schedule of opioid with a rescue dose as needed, calculate opioid dose increase based on the total 24-hour dose (around the clock/scheduled and as needed doses), when possible, use the same short-acting and long-acting opioid formulation, and simplify regimen for improved adherence.

In theory, opioids have no maximum or ceiling dose; however recent guidelines suggest close evaluation of individuals using large doses of opioid medications to identify unique opioid related adverse effects.

Oxycodone is a full opioid receptor agonist that is relatively selective for the opioid mu-receptor, although it can bind to other opioid receptors at high doses. The precise mechanism of action of opioid analgesics is not known but the effects are thought to be mediated through opioid-specific receptors located predominantly in the CNS.

Definitions:

CDC Recommendations for Opioid Prescribing for Chronic Pain:

A. Determining when to initiate or continue opioids for chronic pain

1. Opioids are not first-line or routine therapy for chronic pain
2. Establish and measure goals for pain and function
3. Discuss benefits and risks and availability of non-opioid therapies with patient

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B. Opioid selection, dosage, duration, follow-up, and discontinuation

1. Use immediate-release opioids when starting
2. Start low and go slow-Use caution at any dose and avoid increasing to high dosages
3. When opioids are needed for acute pain, prescribe no more than needed
    - Do NOT prescribe ER/LA opioids for acute pain
4. Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if opioids cause harm or are not helping

C. Assessing risk and addressing harms of opioid use

1. Evaluate risk factors for opioid-related harms
2. Check CSPMP for high dosages and prescriptions from other providers at the beginning of the treatment and at least quarterly while on the opioid treatment
3. Use urine drug testing to identify prescribed substances and undisclosed use
4. Avoid concurrent benzodiazepine and opioid prescribing
5. Arrange treatment for opioid use disorder if needed

Prescriber Education:

- Guidelines for Prescribing Opioids for Chronic Pain
  https://www.cdc.gov/drugoverdose/pdf/TurnTheTide_PocketGuide-a.pdf
  http://www.agencymeddirectors.wa.gov/Files/FY16-288SummaryAMDGOpioidGuideline_FINAL.pdf
  https://www.cdc.gov/drugoverdose/pdf/Guidelines_Factsheet-a.pdf

- Checklist for prescribing opioids for chronic pain
  https://www.cdc.gov/drugoverdose/pdf/PDO_Checklist-a.pdf

- Tapering Opioids for Chronic Pain
  https://www.cdc.gov/drugoverdose/pdf/Clinical_Pocket_Guide_Tapering-a.pdf

- Non-Opioid Treatments
  https://www.cdc.gov/drugoverdose/pdf/nonopioid_treatments-a.pdf

- Assessing Benefits and Harms of Opioid
  https://www.cdc.gov/drugoverdose/pdf/Assessing_Benefits_Harms_of_Opioid_Therapy-a.pdf

- Calculating Total Daily Dose of Opioids for Safer Dosage
  https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf
- Checking Controlled Substances Prescription Monitoring Program (CSPMP)
  https://arizona.pmpaware.net/login
  https://pharmacypmp.az.gov/

- Educational Webinar Series for Prescribers
  https://www.cdc.gov/drugoverdose/pdf/COCA-webinar-series-allslides-a.pdf
  https://www.cdc.gov/drugoverdose/prescribing/trainings.html
  http://www.coperems.org/

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- CDC Guideline for Prescribing Opioids for Chronic Pain
  https://www.cdc.gov/drugoverdose/prescribing/clinical-tools.html
- Washington State Opioid Taper Plan Calculator
  www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf
- Tapering Long-Term Opioid Therapy in Chronic Non-cancer Pain
  www.mayoclinicproceedings.org/article/S0025-6196(15)00303-1/fulltext
- UpToDate
  https://www-uptodate-com.mwu.idm.oclc.org/contents/overview-of-the-treatment-of-chronic-non-cancer-pain?source=search_result&search=non-cancer%20pain&selectedTitle=1~150

Opioid Risk Assessment Tool:

Score each that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disorders		
ADD,OCD, Bipolar, Schizophrenia	2	2
Depression	1	1
Total score		
Assessment of risk		
Low risk for abuse	≤ 3	
Moderate risk for abuse	4-7	
High risk for abuse	≥ 8	
Definitions of risk		
Low = unlikely to abuse Moderate = as likely will as will not abuse High = likely to abuse		

XTAMPZA ER™ (oxycodone) extended-release oral capsule (cont.)

Resources:

Webster LR and Webster RM: Predicting Aberrant Behaviors in Opioid-treated Patients: Preliminary Validation of the Opioid Risk Tool. Pain Medicine 2005;6(6):432-442

Xtampza ER. Package Insert. Revised by manufacturer 11/2017. Accessed 02-23-2018.

Xtampza ER. Package Insert. Revised by manufacturer 12/2016. Accessed 07-10-2017.

Xtampza ER. Package Insert. Revised by manufacturer 04/2016. Accessed 05-19-2016.

Off Label Use of Cancer Medications: A.R.S. §§ 20-826(R) & (S). Subscription contracts; definitions.

Off Label Use of Cancer Medications: A.R.S. §§ 20-1057(V) & (W). Evidence of coverage by health care service organizations; renewability; definitions.

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.**
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Opioid Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information			
Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:
Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:		Office Fax:
Dispensing Pharmacy Information			
Pharmacy Name:	Pharmacy Phone:		Pharmacy Fax:
Requested Medication Information			
Medication Name:	Strength:		Dosage Form:
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: _____ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. Select all applicable diagnoses below.

☐ Confirmed diagnosis of pain severe enough that is not controlled by the current dosage
☐ Confirmed diagnosis of Migraines
☐ Confirmed diagnosis of Neuropathic Pain
☐ Confirmed diagnosis of Osteoarthritis
☐ Confirmed diagnosis of Fibromyalgia
☐ Other diagnosis: _____ ICD-10 Code(s): _____

2. What is the quantity requested per day? _____

3. What is the reason for exceeding the plan limitations? Please specify below (if applicable).

_____

4. For Migraines: Check all applicable non-opioid therapies failed, intolerated, or contraindicated.

PREVENTATIVE TREATMENTS

☐ Anticonvulsants (Topiramate)
☐ Beta-Blockers (Propranolol, Atenolol)
☐ TCAs (Amitriptyline, Imipramine)
☐ Calcium Channel Blockers (Amlodipine, Verapamil)
☐ Non pharmacological treatments (Cognitive behavioral therapy, Relaxation, Biofeedback, Exercise therapy)

ACUTE TREATMENTS

☐ Aspirin, Acetaminophen, NSAIDS (Naproxen, Ibuprofen, Meloxicam, Diclofenac) may be combined with caffeine
☐ Anti-nausea medication (Ondansetron, Promethazine)
☐ Triptans - migraine-specific (Rizatriptan, Sumatriptan)

5. For Neuropathic Pain: Check all applicable non-opioid therapies failed, intolerated, or contraindicated.

☐ TCAs (Amitriptyline, Imipramine)
☐ SNRIs (Duloxetine, Venlafaxine)
☐ Gabapentin/Lyrica
☐ Topical Aspercreme 4% cream or Patches
☐ Non pharmacological treatments (Exercise, Weight loss, patient education)

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Opioid Prior Authorization Request Form

6. For Osteoarthritis: Check all applicable non-opioid therapies failed, intolerated, or contraindicated.

FIRST LINE

- ☐ Acetaminophen
- ☐ Oral NSAIDs (Naproxen, Ibuprofen, Meloxicam, Diclofenac)
- ☐ Topical NSAIDs (Diclofenac Gel)

SECOND LINE

- ☐ Intra-articular hyaluronic acid (OA of the knee only)
- ☐ Capsaicin

7. For Fibromyalgia: Check all applicable non-opioid therapies failed, intolerated, or contraindicated.

- ☐ Duloxetine
- ☐ Lyrica
- ☐ Gabapentin
- ☐ TCAs (Amitriptyline, Imipramine)
- ☐ Non pharmacological treatments (Low impact aerobic exercise such as brisk walking, swimming, water aerobics or bicycling. Cognitive behavioral therapy, biofeedback, interdisciplinary rehabilitation)

8. ☐ Yes ☐ No **A treatment plan must be submitted with this request form that includes ALL of the following:**

- Pain intensity (scales or ratings)
- Functional status (physical and psychosocial)
- Patient's goal of therapy (level of pain acceptable and/or functional status)
- Current non-pharmacological treatment

9. ☐ Yes ☐ No **A physician-patient pain management contract must be submitted with this request form.**

10. ☐ Yes ☐ No **Individual must not be actively using illicit substances or NOT have a drug seeking behavior.**

11. ☐ Yes ☐ No **Results from random urine or blood test twice a year must be submitted with this request form.**

12. ☐ Yes ☐ No **Has the state's Prescription Drug Monitoring Program (PDMP) been reviewed for this individual every time a prescription for controlled substance is provided?**

13. What other controlled substances is the patient currently receiving? Please specify below.

_____

14. One pharmacy (plus one closest 24 hour pharmacy) must be selected for all the controlled substances prescription services. Please specify:

_____

15. ☐ Yes ☐ No **There is NO concomitant use with benzodiazepines-ex. clonazepam, lorazepam, diazepam etc.**

16. ☐ Yes ☐ No **There is absence of ALL contraindications.**

17. What medication(s) has the individual tried and failed for this diagnosis? Please specify below.

Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

18. Are there any supporting labs or test results? Please specify below.

Date	Test	Value

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Opioid Prior Authorization Request Form

19. Is there any additional information the prescribing provider feels is important to this review? Please specify below.

Signature affirms that information given on this form is true and accurate and reflects office notes

Prescribing Provider's Signature: Date:

Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.