Aetna Better Health®

Fax completed prior authorization request form to 855-799-2551 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at
www.aetnabetterhealth.com/michigan/providers/medicaid/pharmacy

Opioids – Short-Acting and Intermediate-Acting - Michigan PDL Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information				
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female		Height:
Member ID:	City:	State:		Weight:

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				
Specify drug:				
Are there any contraindications to formulary medications? (if yes, please specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:
What medication(s) have been tried and failed for this diagnosis? Please specify:		

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information			
☐ **Short and Intermediate Acting Opioids**			
Has the member experienced a therapeutic failure with a ONE WEEK trial of TWO preferred medications?		☐ Yes	☐ No
Does the member have any of the following to the preferred medication(s): check all that apply	☐ Allergy ☐ Contraindication or drug interactions ☐ History of unacceptable side effects		
Is this request for an ORAL fentanyl product (i.e., Actiq, Fentora, or Subsys)? If **YES**, please answer questions to the right.	Is the requested drug being prescribed for the management of breakthrough cancer pain for a member established on immediate release and long-acting opioid therapy?	☐ Yes	☐ No
	Is this request for controlled substances under the name and ID of the prescribing physician?	☐ Yes	☐ No
	Is the requested drug being prescribed by a physician who is experienced in the use of Schedule II opioids?	☐ Yes	☐ No

☐ Yes ☐ No	Has the current dosage regimen of the long acting and regularly prescribed immediate release opioids been maximally optimized?	☐ Yes	☐ No
	Will there be concomitant use of other inducers or inhibitors of cytochrome P450?	☐ Yes	☐ No
Is this request for tramadol (Qdolo) Oral Solution? If **YES**, please answer the question to the right. ☐ Yes ☐ No	Does the member have difficulty swallowing tablets?	☐ Yes	☐ No
Is this request for Seglentis (celecoxib/tramadol)? If **YES**, please the answer question to the right. ☐ Yes ☐ No	Does the prescriber attest that medication will not be used for postoperative management in children younger than 18 years of age following tonsillectomy and/or adenoidectomy?	☐ Yes	☐ No
Is the request for a codeine or tramadol containing product? ☐ Yes ☐ No	Is the member 12 years of age or older?	☐ Yes	☐ No
☐ **Initial High Morphine Milligram Equivalents (MME)**			
Does the member have any of the exceptions listed to the right? If **YES**, no further questions. ☐ Yes ☐ No	Does the member have documented "current" cancer-related pain?	☐ Yes	☐ No
	Does the member have pain related to sickle cell disease?	☐ Yes	☐ No
	Is the member in hospice or palliative care?	☐ Yes	☐ No
	Does the member reside in a long-term care facility that is exempt from reporting to or checking the State Prescription Monitoring Program (i.e., MAPS)	☐ Yes	☐ No
☐ **Additional High Morphine Milligram Equivalents (MME)**			
Prescriber attests to all of the following? ☐ Yes ☐ No	Risk assessment has been performed?	☐ Yes	☐ No
	Pain Medication Agreement with informed consent has been reviewed with, completed, and signed by the member?	☐ Yes	☐ No
	MAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.)	☐ Yes	☐ No
	Concurrently prescribed drugs have been reviewed and that based on prescriber's assessment the drugs and doses are safe for the member?	☐ Yes	☐ No
	Concurrently prescribed drugs have been reconciled and reviewed for safety	☐ Yes	☐ No
	Non-opioid medications have been recommended and/or utilized?	☐ Yes	☐ No
	Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss, have been recommended and/or utilized?	☐ Yes	☐ No
	A toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals?	☐ Yes	☐ No
	Results from toxicology screen showed expected results?	☐ Yes	☐ No
	Member has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit?	☐ Yes	☐ No
	Member has been counselled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g., benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers)?	☐ Yes	☐ No
Has documentation been submitted? ☐ Yes ☐ No	Current documentation provided outlining pain related to history and physical(s) including clinical justification supporting need for exceeding high MME?	☐ Yes	☐ No
	Recent non-opioid medications utilized for pain management or rationale these cannot be used?	☐ Yes	☐ No
	Documentation includes lists of all current opioid medications (long and short-acting) and when the regimen was initiated?	☐ Yes	☐ No
	Has the member's current daily Morphine Milligram Equivalent been calculated?	☐ Yes	☐ No
	Pregnant patients on opioids are considered high-risk patients and need to be followed by an OB/GYN. If member is pregnant has the name of the OB/GYN been submitted with request?	☐ Yes	☐ No
☐ **Renewal**			
Has **documentation been submitted** showing the member continues to meet high MME criteria? ☐ Yes ☐ No	Has **documentation** of taper plan or rationale why taper is not appropriate **been submitted?**	☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records			

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

Prescribing Provider's Signature: _____ **Date:** _____

Please note: 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.

Standard turnaround time is 24 hours. You can call 855-300-5528 to check the status of a request.