Priority Partners MCO
7231 Parkway Drive, Suite 100
Hanover, MD 21076

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE

Prior Authorization

JOHNS HOPKINS HEALTHCARE (MEDICAID)

Opioids - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Healthcare at **1-410-424-4607**.
Please contact Johns Hopkins Healthcare at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Opioids - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Other, Please specify

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 3.]

2. Has the prescriber documented clinical benefit and patient improvement from therapy? Y N _____

[Note: Documentation must be submitted.]

	[No further questions.]		
3.	Is the patient currently taking or has a recent history of treatment for opiate dependence, including treatment with Suboxone, buprenorphine (Subutex), or methadone maintenance programs?	Y N	
	[If yes, then no further questions.]		
4.	Is this request for select short-acting non-formulary sublingual and nasal fentanyl products such as fentanyl buccal tablets, Actiq, Fentora, Onsolis, Abstral, and Lazanda?	Y N	
	[If no, then skip to question 9.]		
5.	Is the patient opioid tolerant and has the diagnosis of breakthrough pain while already receiving opioid therapy for underlying persistent cancer pain?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
6.	Does the patient have documentation of trial and failure of an adequate dose of at least one formulary short-acting opiate?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
7.	Does the patient have documentation of adequate dosing of a long-acting (maintenance, around-the-clock) opioid?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
8.	Has the prescriber documented that the patient is able to comply with child-safe storage and disposal requirements?	Y N	
	[Note: Documentation must be submitted.]		
	[No further questions.]		
9.	Is this request for a non-formulary opioid?	Y N	
	[If no, then skip to question 12.]		
10.	Is there evidence of medical necessity supported with documentation of ONE of the following: A) Therapeutic failure of two or more different formulary opioids within the same therapeutic class (if available) within the previous 180 days per pharmacy claims, B) Allergy to one formulary drug, C) Successful drug maintenance on the requested medication when changing to an alternative drug may produce a potential health risk, D) Previous medical history pertaining to the requested medication?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
11.	Does the prescriber attest to ALL of the following: A) Prescriber has reviewed controlled substance prescriptions in the Prescription Drug Monitoring Program	Y N	

through CRISP (Chesapeake Regional Information System) for prescriptions from other providers, B) Patient will have random urine drug screen, C) Naloxone prescription has been provided or offered to patient/patient's household, D) A Patient-Prescriber Pain Management/Opioid Treatment Agreement/Contract has been signed, and placed in the patient's medical record?		
[Note: Documentation must be submitted.]		
[No further questions.]		
12. Is this request for a formulary long-acting opioid?	Y N	
[If no, then skip to question 15.]		
13. Does the patient have a diagnosis of cancer or sickle cell anemia OR is the patient in hospice care, long-term care, or palliative care?	Y N	
[Note: Documentation must be submitted.]		
[If yes, then no further questions.]		
14. Does the prescriber attest to ALL of the following: A) Prescriber has reviewed controlled substance prescriptions in the Prescription Drug Monitoring Program through CRISP (Chesapeake Regional Information System) for prescriptions from other providers, B) Patient will have random urine drug screen, C) Naloxone prescription has been provided or offered to patient/patient's household, D) A Patient-Prescriber Pain Management/Opioid Treatment Agreement/Contract has been signed, and placed in the patient's medical record?	Y N	
[Note: Documentation must be submitted.]		
[No further questions.]		
15. Is this request for a formulary short-acting opioid that exceeds the plan's quantity limit?	Y N	
[If no, then no further questions.]		
16. Is the requested quantity greater than 90 morphine milligram equivalents (MME) per day?	Y N	
[If no, then skip to question 19.]		
17. Does the patient have a diagnosis of cancer or sickle cell anemia OR is the patient in hospice care, long-term care, or palliative care?	Y N	
[Note: Documentation must be submitted.]		
[If yes, then no further questions.]		
18. Does the prescriber attest to ALL of the following: A) Prescriber has reviewed controlled substance prescriptions in the Prescription Drug Monitoring Program through CRISP (Chesapeake Regional Information System) for prescriptions from other providers, B) Patient will have random urine drug screen, C) Naloxone prescription has been provided or offered to	Y N	

patient/patient's household, D) A Patient-Prescriber Pain Management/Opioid Treatment Agreement/Contract has been signed, and placed in the patient's medical record?		
[Note: Documentation must be submitted.]		
[No further questions.]		
19. Does the patient have a documented diagnosis of severe chronic pain that requires a continuous, around-the-clock opioid analgesic for an extended period of time?	Y N	
[Note: Documentation must be submitted.]		
[If no, then no further questions.]		
20. Has the patient received a recent, documented pain management assessment by a physician?	Y N	
[Note: Documentation must be submitted.]		
[If no, then no further questions.]		
21. Has the patient tried and failed the recommended dosage interval of the requested medication?	Y N	
[Note: Documentation must be submitted.]		
[If no, then no further questions.]		
22. Does the requested dose exceed Food and Drug Administration (FDA) recommendations or accepted clinical dosing guidelines?	Y N	
[If yes, then no further questions.]		
23. Is the patient using an adequate dose of a long-acting (maintenance, around-the-clock) opioid?	Y N	
[If no, then no further questions.]		
24. Have other pain management regimens been inadequate?	Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date