Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Methadone (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Methadone (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Dolophine (methadone hydrochloride)

Methadone/Methadone Intensol (methadone hydrochloride injection; oral solution; oral concentrate)

Methadose (methadone hydrochloride oral concentrate; dispersible tablets; tablets)

Other, specify drug _____

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: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

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

   [If yes, skip to question 11]

2. Is patient 18 years of age or older? Y N

3. Is the methadone being prescribed for treatment of severe chronic pain and not for the management of opioid addiction? Y N

4. Is methadone prescribed on a scheduled basis (not “as needed”)? Y N

5. Will all other long acting opioids be discontinued upon initiation of therapy with methadone? Y N

6. Does the patient have a diagnosis of metastatic cancer supported by progress notes, discharge notes or health conditions? Y N

   [If yes, skip to question 9]

7. Does the patient have a diagnosis of any non-metastatic cancer or chronic non-malignant pain supported by progress notes, discharge notes or health conditions? Y N

8. Has the prescriber provided a copy of the signed pain management agreement documenting ongoing evaluations utilizing monitoring systems such as drug screens, pill counts, etc.? Y N

9. Does patient have a contraindication or history of intractable pain or intolerable adverse effects associated with all preferred long acting opioids? Y N

10. Is the patient opioid tolerant as evidenced by recent history (within the past two weeks) of receiving daily opioid analgesics at the following minimum doses for at least one week A) 60 milligrams oral morphine per day, B) 25 microgram per hour of transdermal fentanyl, C) 30 milligrams of oral oxycodone per day, D) 8 milligrams of oral hydromorphone per day, E) 25 milligrams of oral oxymorphone per day Y N

11. Does the patient meet all of the following: A) continues to meet all of the initial review criteria, B) compliant with medication refills, C) no medication fills for any other long acting opioid, D) no medication fills for opioids from any prescriber other than the methadone prescriber, E) no history of behavior indicative of abuse including requests for early refills? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**