

## FLORIDA MEDICAID PRIOR AUTHORIZATION OPIOID AGENTS

## **LENGTH OF APPROVAL: UP TO 3 MONTHS**

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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Rec	ecipient's Full Name																										
	<ul> <li>Did the prescriber review the Prescribed Drug Monitoring Program prior to prescribing this opioid medication as required by Florida statute?</li> <li>Yes</li> <li>No</li> </ul>																										
	a. If	NO, e	xpla	in why:																							_
	<ul> <li>Submission of a signed patient-prescriber pain management, opioid treatment agreement is required for chronic pain patients</li> </ul>																										
5.	Wher	n is th	e ne	xt office	visit	sched	luled	for the	patier	nt wit	th chi	onic	pain	n? Da	te: _												_
	thera	py? (: ′es	Subm	nission o	of a UI	OS wi	thin 1	ed a uri	90 da	ys is	requ	ired.)	)								to ini	tiatio	n o	of opic	oid		_
Co	ntir	nuat	ion	of O	ngoi	ng 1	آhe	ару																			
	<ul> <li>Has the prescriber ordered and reviewed a UDS for patients with chronic pain to ensure compliance of opioid therapy? (Submission of a UDS within the past 90 days is required.)</li> <li>Yes</li> <li>No</li> </ul>																										
2.	Wher	n is th	e ne	xt office	visit	sched	luled	for the	patier	nt wit	th chi	onic	pain	n? Da	te: _												_
<ul> <li>When is the next office visit scheduled for the patient with chronic pain? Date:</li> <li>If requesting an increase in dose or frequency, calculate the new daily morphine milligram equivalent (MME) of the prescribed medication(s) and provide rationale for why this dose is medically necessary.</li> </ul>																											
			**	**Clinic	ians s	hould	d con	sider of	fering	nalo	xone	to pa	atien	ts wi	th ar	n incr	ease	d r	sk of	opio	id ove	erdos	e.*	***			
	I cert	ify th	at th	e benef	its of	opioi	d tre	atment <sub>.</sub>	for th	is pa	tient	outv	veigl	h the	risk	of tre	eatm	en	<b>:.</b>								
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