aetna™

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 and MME
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				
Short Acting Opioid:	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						
Pain is due to ONE of the following:	☐ Active Cancer	☐ Sickle Cell	☐ Palliative/End of life	☐ Hospice	☐ N/A	
Is request for treatment of ACUTE pain?	☐ Yes	☐ No	Is the request for the treatment of CHRONIC pain?	☐ Yes	☐ No	
Will member be on both opioid AND benzodiazepine at same time?	☐ Yes	☐ No	Will Naloxone be provided/offered and the member or household counseled on use of naloxone?	☐ Yes	☐ No	☐ N/A
Was non-pharmacologic therapy tried PRIOR to prescribing opioids (PT, exercise, CBT OR weight loss)?				☐ Yes	☐ No	
Was non-opioid therapy tried PRIOR to prescribing opioids? (topical diclofenac NSAIDs, TCAs, and SNRIs OR anticonvulsants)				☐ Yes	☐ No	

Signed treatment plan addresses the following (check that apply):	☐ Realistic goals for pain AND function	☐ When treatment will be stopped	☐ Consequences of lost medication	☐ Consequences of obtaining controlled substances from other prescribers	☐ Member using ONE pharmacy

Was member advised of harm AND benefits before treatment AND periodically during treatment (increased risks of respiratory depression, combination use with BNZ, risks to others in household, cognitive limitations AND side effects)?								☐ Yes	☐ No
Will treatment be prescribed at lowest effective dose?								☐ Yes	☐ No
Will Morphine Milligram Equivalents per day of current prescribed dose be calculated?								☐ Yes	☐ No
Will treatment be reviewed within 1-4 weeks of starting opioid therapy for CHRONIC pain AND with any DOSE-ESCALATION AND RE-EVALUATED every 3 months?								☐ Yes	☐ No
Was there review of state's PMP Drug Monitoring Program for controlled substances, with focus on opioid dosages OR dangerous combinations?								☐ Yes	☐ No
Was UDS or serum medication level reviewed prior to starting treatment?		☐ Yes	☐ No	Were results of UDS consistent with prescribed controlled substances?				☐ Yes	☐ No
Is there evidence of substance use disorder?	☐ Yes	☐ No	Was evidence-based treatment arranged (for example MAT)?		☐ Yes	☐ No	☐ N/A		
Has there been a prior overdose?	☐ Yes	☐ No	Is dose ≥50 MME per day?		☐ Yes	☐ No			
Is request for female of reproductive age?	☐ Yes	☐ No	Was counseling provided about opioid use during pregnancy AND neonatal abstinence syndrome?		☐ Yes	☐ No	☐ N/A		

☐ High Morphine M Equivalent

Has this request been submitted with documentation that supports a chronic pain (for example, pain lasting longer than three months) diagnosis that requires continued use of opioid medications	☐ Yes	☐ No	Has a current history and physical been submitted	☐ Yes	☐ No
Has a medication list with all current prescription and OTC medications been submitted?	☐ Yes	☐ No	Has documentation of how long the member has been on opioids has been submitted?	☐ Yes	☐ No
Have current accumulated morphine equivalent daily dose (MEDD) of all prescribed opioids been documented?	☐ Yes	☐ No	Has the length of time on current dose has been documented?	☐ Yes	☐ No

☐ Renewal ONLY

Was there sustained improvement in Pain OR Function?	☐ Yes	☐ No	Was tapering plan initiated to D/C treatment of current medication?	☐ Yes	☐ No	☐ N/A	
Was UDS performed in past year?	☐ Yes	☐ No	Was UDS consistent with prescribed controlled substances?	☐ Yes		☐ No	

The state's PMP was reviewed no less often than every 90 days AND each was verified (check all that apply):	☐ Prescriptions from other providers	☐ Benzodiazepines use	☐ ER / LA use for acute pain upon writing prescription for opioid

Is dose ≥50 MME per day?	☐ Yes	☐ No	Did provider offer Naloxone to member?	☐ Yes	☐ No	☐ N/A
Is dose ≥90 MME per day?	☐ Yes	☐ No	Did provider refer member to or consult with a Pain Specialist?	☐ Yes	☐ No	☐ N/A
Is there continued concomitant use of opioid AND BNZ?	☐ Yes	☐ No	Was member counseled on FDA BBW dangers of concomitant use AND provider will prescribe at LOWEST effective dosage AND duration?	☐ Yes	☐ No	☐ N/A

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.