Print Reset

Alaska Medicaid
Opioid Therapeutic Duplication, Quantity Limit, MME Limit, Extended Release and Second-Level Opioid Prior Authorization Form

This form may also be used for requests to exceed the maximum allowed units.
Form available on Alaska Medicaid's Medication Prior Authorization website

Fax this form to (888) 603-7696

This authorization request does not ensure eligibility and is not a guarantee of payment. Please verify Medicaid eligibility before completing this form. Incomplete requests will be denied until all required information is received.

Request Date: _____

REQUESTOR INFORMATION

Requestor Name: _____ Title: _____

MEMBER INFORMATION

Last Name: _____ First Name: _____

Member ID #: _____ Date of Birth: _____

Sex: ☐ Male ☐ Female Member Phone: _____

PRESCRIBER INFORMATION

Last Name: _____ First Name: _____

Prescriber NPI: _____ Specialty: _____

Prescriber Phone: _____ Prescriber Fax: _____

PHARMACY INFORMATION

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

DRUG INFORMATION

Drug Name: _____ NDC: _____

Drug Strength: _____ Dosage Form: _____

Dosage Schedule: _____ Quantity: _____ Day Supply: _____

Is this a physician-administered drug? ☐ Yes ☐ No

Last Name: _____ First Name: _____

CLINICAL INFORMATION

1. Requested PA start date: _____ and duration: _____mos.
2. Reason for request:
   - ☐ Product Selection – Extended-Release (ER) Opioid
   - ☐ Therapeutic Duplication (TD) – Short or ER Opioid
   - ☐ Exceed Quantity Limit (QL) – Short or ER Opioid
   - ☐ Second-Level Opioid Review: ☐ TD ☐ QL ☐ Other
3. Is patient opioid-tolerant?
   ☐ Yes ☐ No If Yes: _____ years _____ months
4. Current Medication List: ☐ attached ALL
   (must include all medications, doses, and directions regardless of payment source).
5. Calculated total daily Morphine Equivalent Dose (MED)ALL: From all opioids, including PRN, from all prescribers (regardless of payment source): _____
6. Medical Justification (attached)
   - ☐ Letter of Medical Necessity ALL
   - ☐ Treatment Plan – pain management RW
   - ☐ Chart Notes (6 months required for second-level review requests) RW
   - ☐ Pain Contract ALL
   - ☐ Pain Specialist Notes RW
   - ☐ Medical Rationale for Non-trial of Preferred Agents (attached) RW
7. Previously trialed opioid agents RW (include daily dose, dates, reason for discontinuation):

ALL – Required for all requests. RW – Required when necessary to demonstrate clinical justification and for all requests that require second level review.

Attestation: I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Alaska Medicaid.

Prescriber Signature: _____ **Date:** _____

Magellan Medicaid Administration, PA Unit
14100 Magellan Plaza
Maryland Heights, MO 63043
Phone: (800) 331-4475

Fax this form to (888) 603-7696

Information Regarding Second-Level Reviews

Prior authorization requests requiring second-level reviews will be escalated to the State of Alaska for review by a physician who has completed a residency in anesthesiology and an ACGME-accredited subspecialty fellowship in pain medicine. Once all required information has been received, please allow time for the State to review.

Second-level reviews may be requested for:

- Review of a previous denial decision of quantity limit exceptions or therapeutic duplications on the Alaska Medicaid Prior Authorization website and Alaska Opioid Therapeutic Duplication Edits Letter.
- Exceptional circumstances

Required Documentation

Prescribers submitting documentation for second-level review requests should ensure that the following documentation is attached:

- ☐ Letter of medical necessity from the prescriber detailing the need for prescribed therapy, including all medications the recipient is taking. ***(required)***
- ☐ Documentation of previous treatment failures including start and stop dates and the last 6 months of progress notes. ***(required)***
- ☐ Pain management treatment plan including a copy of the current pain contract or opioid agreement. ***(required)***
- ☐ Documentation from a pain specialist supporting the prescribed therapy.
- ☐ Whether patient is new to Medicaid with no previous Medicaid claims for requested or other pain medication(s).

Additional Resources

- State of Alaska Prescription Drug Monitoring Program website
- Sample Pain Contracts from the NIH NIDA website
- Opioid and Pain Management CMEs/CEs from the NIH NIDA website

The State of Alaska will contact the Magellan Pharmacy Care Center and the prescriber will be advised of the determination once the submitted documentation has been evaluated by the reviewing physician. If the request is denied, the prescriber will be provided with an opportunity to speak with the physician reviewer to discuss the determination or provide additional information.
