



**Request for Prior Authorization**  
**SHORT ACTING OPIOIDS - continued**  
(PLEASE PRINT – ACCURACY IS IMPORTANT)

**Document non-pharmacologic therapies** (such as physical therapy, weight loss, alternative therapies such as manipulation, massage, and acupuncture, or psychological therapies such as cognitive behavior therapy [CBT], etc.)

Non-Pharmacological Treatment Trial #1: \_\_\_\_\_  
Trial Dates: \_\_\_\_\_ Failure reason: \_\_\_\_\_

Non-Pharmacological Treatment Trial #2: \_\_\_\_\_  
Trial Dates: \_\_\_\_\_ Failure reason: \_\_\_\_\_

**Document 2 nonopioid pharmacologic therapies** (acetaminophen or NSAIDs)

Nonopioid Pharmacologic Trial #1: Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

Nonopioid Pharmacologic Trial #2: Name/Dose: \_\_\_\_\_ Trial Dates: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Document trials with three preferred chemically distinct short acting opioids**

**Preferred Trial 1:** Drug Name \_\_\_\_\_ Strength \_\_\_\_\_ Dosage Instructions \_\_\_\_\_  
Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Preferred Trial 2:** Drug Name \_\_\_\_\_ Strength \_\_\_\_\_ Dosage Instructions \_\_\_\_\_  
Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Preferred Trial 3:** Drug Name \_\_\_\_\_ Strength \_\_\_\_\_ Dosage Instructions \_\_\_\_\_  
Trial start date: \_\_\_\_\_ Trial end date: \_\_\_\_\_  
Failure reason: \_\_\_\_\_

**Prescriber review of patient's controlled substances use on the Iowa PMP website:**  No  Yes Date Reviewed: \_\_\_\_\_

**Is short-acting opioid use appropriate for patient based on PMP review and patient's risk for opioid addiction, abuse and misuse?**  No  Yes

**Has patient been informed of the common adverse effects (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids) and serious adverse effects (potentially fatal overdose and development of a potentially serious opioid use disorder) of opioids?**

No  Yes

**Patients taking concurrent benzodiazepines:**

Have the risks of using opioids and benzodiazepines concurrently been discussed with the patient?  No  Yes

Medical necessity for concurrent use: \_\_\_\_\_

Provide plan to taper the benzodiazepine or medical rationale why not appropriate: \_\_\_\_\_

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**Renewals**

**Has patient experienced improvement in pain control and level of functioning?**

No  Yes (describe): \_\_\_\_\_

**Updated prescriber review of patient's controlled substances use on the Iowa PMP website (since initial request):**

No  Yes Date Reviewed: \_\_\_\_\_

***Continued use of a short-acting opioid is appropriate for this member?***

No  Yes (describe): \_\_\_\_\_

**Patients taking concurrent benzodiazepines:**

Have the risks of using opioids and benzodiazepines concurrently been discussed with the patient?  No  Yes

Medical necessity for concurrent use: \_\_\_\_\_  
 \_\_\_\_\_

Provide plan to taper the benzodiazepine or medical rationale why not appropriate: \_\_\_\_\_  
 \_\_\_\_\_

Other medical conditions to consider: \_\_\_\_\_

***Attach lab results and other documentation as necessary.***

Prescriber signature (Must match prescriber listed above.)	Date of submission
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***IMPORTANT NOTE:*** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.