Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Dolophine® (methadone) & Methadose™ (methadone) Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Chronic pain (90 days or greater)
- ❑ Associated with cancer, hospice care, palliative care, OR treatment in a long-term care facility
- ❑ **Not** associated with cancer, hospice care, palliative care, OR treatment in a long-term care facility

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the prescriber's specialty ONE of the following: Chronic pain, oncology, palliative care, OR sickle cell? ❑ **Yes** ❑ **No**

Select if the patient has tried and failed the following long-acting opioids:

- ❑ Buprenorphine transdermal (Butrans)
- ❑ Fentanyl patches (generic Duragesic)
- ❑ Morphine sulfate beads SR capsules (generic Avinza)
- ❑ Morphine sulfate CR tablets (generic MS Contin)
- ❑ Morphine sulfate SR capsules (generic Kadian)
- ❑ Tramadol HCl biphasic SR capsules (generic Conzip)
- ❑ Tramadol HCl SR tablets (generic Ultram ER)

Is the patient established on methadone? ❑ **Yes** ❑ **No**
** *Please note: Chart documentation is required to be submitted along with this fax*

Chronic pain (90 days or greater) not associated with cancer, hospice care, palliative care, OR treatment in a long-term care facility, also answer the following:

Does the prescriber attest that a treatment plan with goals that address benefits and harm has been established with the patient and there is a SIGNED AGREEMENT with the patient? ❑ **Yes** ❑ **No**
Please note: This will be reviewed with the patient within 1 to 4 weeks of starting opioid therapy for chronic pain, with dose escalation and is reviewed every 3 months or more frequently

Has the prescriber ordered and reviewed a urine drug screen (UDS) or serum medication level per the following requirements: If initiating treatment, prior to initiation; OR If maintaining treatment, at least every 3 months for the first year of treatment and at least every 6 months thereafter to ensure adherence? ❑ **Yes** ❑ **No**

<continued on the next page>

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Dolophine® (methadone) & Methadose™ (methadone) Prior Authorization Request Form (Page 2 of 2)

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<continued from the previous page>

Is the patient's Active Daily morphine milligram equivalent (MME) greater than or equal to 120? ❑ **Yes** ❑ **No**

If **yes**, select if the prescriber attests to the following:

- ❑ He/she acknowledges the warnings associated with high dose opioid therapy including fatal overdose, and that therapy is medically necessary for this patient
- ❑ He/she has prescribed naloxone
- ❑ He/she has reviewed the Virginia BOM Regulations for Opioid Prescribing
- ❑ He/she will be managing the patient's opioid therapy long term

Has a benzodiazepine been filled in the past 30 days? ❑ **Yes** ❑ **No**

If **yes**, select if the prescriber attests to the following:

- ❑ He/she has counseled the patient on the FDA black box warning on the dangers of prescribing Opioids and Benzodiazepines including fatal overdose
- ❑ He/she has documented that the therapy is medically necessary
- ❑ He/she has recorded a tapering plan to achieve the lowest possible effective doses of both opioids and benzodiazepines per the Board of Medicine Opioid Prescribing Regulations

Has Naloxone been prescribed for patients with risk factors of prior overdose, substance use disorder, doses in excess of 120 MME/day, or concomitant benzodiazepine? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

Does the patient have a diagnosis of cancer pain? ❑ **Yes** ❑ **No**

Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:

_____

_____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

*** Please note: Documentation of the above is required to be submitted along with this fax*

_____

_____

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****
Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.