

**State of Maine Department of Health & Human Services  
MaineCare/MEDEL Prior Authorization Form  
NARCOTICS – LONG ACTING**

[www.mainearepdl.org](http://www.mainearepdl.org)

Phone: 1-888-445-0497

**ONE Drug Per Form ONLY – Use Black or Blue Ink**

Fax: 1-888-879-6938

Member ID #: <input type="text"/> <small>(NOT MEDICARE NUMBER)</small>	Patient Name: _____	DOB: _____
Patient Address: _____		
Provider DEA: <input type="text"/>	Provider NPI: <input type="text"/>	
Provider Name: _____		Phone: _____
Provider Address: _____		Fax: _____
Pharmacy Name: _____	Rx Address: _____	Rx phone: _____
<b>Provider must fill all information above. It must be legible, correct and complete or form will be returned.</b>		
(Pharmacy use only): NPI: <input type="text"/> NABP: <input type="text"/> NDC: <input type="text"/>		

**Oxycontin will be available without PA with diagnosis of Cancer or Hospice.**

Preferred long acting narcotics: **Butrans, Xtampa ER, Nucynta ER, Morphine Sulfate ER Tabs or Fentanyl Patch**

Drugs Needing PA (Step Order)	Strength	Dosage Instructions	Quantity	Days Supply <small>(34 retail / 90 mail order)</small>	PA Approval Period (mos)
<input type="checkbox"/> DURAGESIC (8)	_____	_____	_____	_____	1 2 3 4 5
<input type="checkbox"/> KADIAN (8)	_____	_____	_____	_____	1 2 3 4 5
<input type="checkbox"/> MS CONTIN (8)	_____	_____	_____	_____	1 2 3 4 5
<input type="checkbox"/> OXYCONTIN (8)	_____	_____	_____	_____	1 2 3 4 5
<input type="checkbox"/> ORAMORPH SR (8)	_____	_____	_____	_____	1 2 3 4 5
<input type="checkbox"/> OTHER _____	_____	_____	_____	_____	1 2 3 4 5

**Preferred treatment failures:**

- Three preferred generic NSAIDs failed/not tolerated (describe):  
\_\_\_\_\_
  
- Three preferred long acting narcotics failed/not tolerated and must show medications to alleviate adverse event (such as nausea/ vomiting/ constipation/itching) or submit clinical rationale why this is inappropriate. (attach chart notes)  
Drug One: \_\_\_\_\_  
\_\_\_\_\_  
Drug Two: \_\_\_\_\_  
\_\_\_\_\_  
Drug Three: \_\_\_\_\_  
\_\_\_\_\_
  
- Failed on non preferred step order (attach chart notes): \_\_\_\_\_

Explain need if Fentanyl or Duragesic requested for frequency greater than every 3 days (e.g. 2 days): \_\_\_\_\_

- Please submit evidence of full pain evaluation from pain specialist (see criteria on pg. 2 that will be applied) and if applicable attach pain program evaluation supporting Oxycontin use.

**State of Maine Department of Human Services**  
**PRIOR AUTHORIZATION FORM**  
**NARCOTICS (continued)**

Chronic, Noncancer pain opioid criteria: Chart documentation to satisfy the following must be supplied:

Evaluation of Patient

- Pain HX, impact on social, occupational, physical, psychological function
- Review prior diagnostic studies, consults, therapies, surgeries . . .
- Review medical, psychiatric, and substance abuse HX, coexisting conditions
- Directed physical exam
- Failure of reasonable pain management choices such as physical therapy, cognitive behavioral techniques, and medical techniques
- Failure of at least two non-opioid adjuvant drugs to replace, reduce opioids (anticonvulsants, tricyclics, steroids, NSAID, etc.)

Treatment plan/objectives

- Working DX and indications for opioids
- Outline measurable outcomes (pain control, ADL's, functional improvements)
- Informed consent on risks/ benefits of opioids
- Conditions discussed under which opioids will be prescribed and discontinued

Periodic Review

- Assess safety/efficacy of treatment (pain ratings, quality of life, side effects . . .)
- Assess compliance and evidence of misuse
- Reassess nature of pain to confirm opioids still indicated
- Follow all other requirements as specified by Board of Licensure in Medicine re: opioids and standard of care
- Strong consideration of drug assays and/or periodic provider supervised Oxycontin<sup>®</sup> dose administration

Consultation

Referral to pain medicine specialist if situation complex or if  $\geq 120$ mg per day of Oxycontin<sup>®</sup> necessary

Referral to addiction specialist if HX of addiction/substance abuse

Referral to psychiatrist/psychologist if significant psychiatric co-morbidity

Proper Documentation

- Evaluation
- DX
- All written scripts
- Overall pain plan
- All consults, relevant report data
- Written instructions, consent, agreements/contracts

**Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.**

Provider Signature: \_\_\_\_\_ Date of Submission: \_\_\_\_\_

**\*MUST MATCH PROVIDER LISTED ABOVE**