MHS PHARMACY BENEFIT
PRIOR AUTHORIZATION REQUEST TO EXCEED DAILY OPIOID MME LIMIT FORM

MHS
550 N. Meridian St. Suite 101
Indianapolis, IN, 46204-1208
Phone: (877) 647-4848 Fax: (866) 399-0929

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.
****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retroactive PA ☐	Date(s) of service requested for retroactive eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication	Strength	Quantity	Dosage Regimen	Anticipated Duration of Regimen

If the request is for Authorization to Exceed MME Daily Limit

Please complete the following for members needing to exceed current daily MME limit and who do not meet exclusion criteria based on cancer, palliative care, sickle cell or terminal illness diagnoses (***ALL responses provided will be evaluated to assess medical necessity***)

1. Member specific diagnosis(es) causing pain leading to chronic or subacute use (specific description of pain or medical justification with submission of supporting chart documentation is preferred):

_____

_____

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2. Non-pharmacologic therapies and non-opioid treatments tried/failed and/or currently active (please provide associated dates, dosages, frequencies, and reason for treatment failure):

Pharmacologic Therapy	Dose	Frequency	Date Initiated	Date Stopped

Non-Pharmacologic Therapy	Date Initiated	Date Stopped

Please provide reason for treatment failure of above non-pharmacologic/pharmacologic therapies:

_____

_____

_____

_____

_____

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3. Does provider have an alternate taper plan ☐ Yes ☐ No
Please provide details (dose and duration) of alternate taper plan or if no alternate taper plan, please provide rationale for not having a taper plan:

_____

_____

_____

_____

4. Has provider attempted dose reduction within the past 12 months? ☐ Yes ☐ No
If so, please provide chart documentation of associated dates and outcomes (including dose and duration of taper):

_____

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5. Please check **YES** or **NO** that the provider attests to completing the following:

Provider Attestations	YES	NO
Member evaluated using validated opioid utilization risk assessment		
Member educated on risks associated with opioids		
INSPECT reviewed (per IC 35-48-7-11.1, DO NOT attach a copy of the INSPECT report to this PA request)		
Mental health evaluation performed, patient adequately treated, or provider referral placed		
Naloxone education performed and prescription provided if needed (recommended for all members utilizing opioids at 50 MME per day or greater)		
Pain care agreement or contract in place		