COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

METHADONE

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

Is Member Over 18 Years of Age? ☐ **Yes** ☐ **No**

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

Prescriber's Specialty:

☐ **Oncology** ☐ **Pain specialist** ☐ **Sickle cell** ☐ **Palliative care** ☐ **Other**: _____

DRUG INFORMATION

Strength: _____

Directions: _____

Quantity Requested: _____

Total Daily Dose: _____

DIAGNOSIS

☐ Metastatic neoplasia ☐ Sickle cell ☐ Chronic severe pain ☐ Other: _____

(Form continued on next page.)

 Revised: 10/28/2022 | Effective: 07/01/2020

Member's Last Name:

Member's First Name:

1. **Does prescriber attest that the member has intractable pain associated with active cancer, palliative care (treatment of symptoms associated with life limiting illnesses), or hospice care? (IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED.)**

   ☐ **Yes** ☐ **No**

HISTORY

2. Is this member an infant discharged from the hospital on a methadone taper (under 1 year of age)?

   ☐ Yes ☐ No

3. Does the member have a contraindication to all other long-acting opioids? (Send MedWatch form.)

   ☐ Yes ☐ No

4. Is the member CURRENTLY taking any of the following? Please indicate which.

   ☐ Single entity immediate release or extend release opioids ☐ Benzodiazepines

   ☐ Barbiturates ☐ Carisoprodol ☐ Meprobamate

5. Does the member have a history of (or ever received treatment for) drug dependency or drug abuse?

   ☐ Yes ☐ No

PRESCRIPTION MONITORING PROGRAM (PMP)

https://www.pmp.dhp.virginia.gov/VAPMPWebCenter/login.aspx

6. The Prescriber has checked the PMP on the date of this request to **determine whether the member is receiving opioid dosages or dangerous combinations (such as opioids and benzodiazepines) that put him or her at high risk for fatal overdose.**

   ☐ Yes ☐ No

7. Document the **fill date** for the member's last **opioid** Rx: _____

8. Document the **fill date** for the member's last **benzodiazepine** Rx: _____

9. Document the member's total drug Morphine Milligram Equivalents from the PMP site: _____ MME/day

10. For MME:

    ☐ From 51 to 90 MME/day (Prescriber should consider offering a prescription for naloxone and overdose prevention education)

    ☐ > 90 MME/day (Prescriber should consider offering a prescription for naloxone and provide overdose prevention education; plus consider consultation with a pain specialist).

Naloxone injection 0.4 mg/mL and 1 mg/mL vials and syringes and Narcan® Nasal Spray (4 mg of naloxone hydrochloride/0.1 mL spray) are available without a service/prior authorization. Evzio® requires a service authorization.

(Form continued on next page.)

Member's Last Name:

Member's First Name:

TREATMENT PLAN

FDA BLACK BOX WARNING: Health care professionals should limit prescribing opioid pain medicines with benzodiazepines or other CNS depressants only to patients for whom alternative treatment options are inadequate. If these medicines are prescribed together, limit the dosages and duration of each drug to the minimum possible while achieving the desired clinical effect. Warn patients and caregivers about the risks of slowed or difficult breathing and/or sedation, and the associated signs and symptoms. Avoid prescribing prescription opioid cough medicines for patients taking benzodiazepines or other CNS depressants, including alcohol. For more information visit http://www.fda.gov/Drugs/DrugSafety/ucm518473.htm.

11. Have you counseled your member of the risks associated with combined use of benzodiazepines and opioids?

☐ Yes ☐ No

Tapering Guidelines for Opioids and Benzodiazepines: http://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-and-Benzodiazepine-Tapering-flow-sheets.pdf

12. Prescriber attests that a treatment plan with goals that addresses benefits and harm has been established with the member and the following bullets are included. Plus, there is a SIGNED agreement with the member.
    - Established expected outcome and improvement in both pain relief and function or just pain relief, as well as limitations (i.e., function may improve yet pain persists OR pain may never be totally eliminated)
    - Established goals for monitoring progress toward member-centered functional goals; e.g., walking the dog or walking around the block, returning to part-time work, attending family sports or recreational activities, etc.
    - Goals for pain and function, how opioid therapy will be evaluated for effectiveness and the potential need to discontinue if not effective.
    - Emphasize serious adverse effects of opioids (including fatal respiratory depression and opioid use disorder, OR alter the ability to safely operate a vehicle)
    - Emphasize common side effects of opioids (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, withdrawal)

☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

Sample Physician/Patient Agreement: www.drugabuse.gov/sites/default/files/files/samplepatientagreementforms.pdf

13. A presumptive urine drug screen (UDS) MUST be done at least annually. The UDS must check for the prescribed drug plus a minimum of 10 substances including heroin, prescription opioids, cocaine, marijuana, benzodiazepines, amphetamines, and metabolites. **Copy of the most recent UDS is attached.**

    ☐ Yes ☐ No

    If No, please explain: _____

    _____

_____ _____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

I attest that all information is accurate. ☐ Yes ☐ No

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Magellan Medicaid Administration / ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060