**STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES**
**TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110**

(This and other PA forms are posted on www.ctdssmap.com and can be accessed by clicking on the pharmacy icon)

# CT Medical Assistance Program
# Opioid Prior Authorization (PA) Request Form
## To Be Completed By Prescriber

| Prescriber Information | Patient Information |
|---|---|
| Prescriber's NPI: | Patient Medicaid ID Number: |
| Prescriber Name: | Patient Name: |
| Phone #: ( ) | Patient DOB: / / |
| Fax #: ( ) | Primary ICD Diagnosis Code: |
| **Prescription Information** | |
| Drug Requested: | Dose/frequency: |
| □ New therapy □ Continuation | Expected Duration: |

**This form must be completed by the prescribing provider. If the form is missing information, the PA will not be processed.**

## Clinical Information

| | |
|---|---|
| Is the patient 12 years of age or older? | □ Yes □ No |
| Does the patient have any of the following diagnoses: 1) cancer-associated pain syndrome, 2) sickle cell pain syndrome, 3) severe arthritis, 4) post-traumatic pain syndrome, 5) renal colic, 6) pancreatitis, 7) avascular necrosis, 8) spinal compression fracture(s), or 9) painful cutaneous ulcers/wounds | □ Yes □ No |
| Do you attest to all of the following factors or conditions concerning this patient:<br>• non-opioid alternatives are either inappropriate or have not been effective without concurrent opioid therapy<br>• an initial 7-day prescription has already been given, the patient reassessed, and a decision made that ongoing opioid treatment is medically necessary<br>• the patient has not previously sustained and survived an opioid overdose and does not have untreated opioid use disorder<br>• the CT Prescription Monitoring Program has been checked and a risk assessment for opioid misuse, diversion, and addiction has been done<br>• the patient does not have known severe respiratory depression/hypercarbia likely to be worsened using opioid therapy | □ Yes □ No |

**If you answered 'NO' to any of the questions above, a Letter of Medical Necessity (LMN) must be reviewed for consideration. Please provide all relevant information relating to the medical necessity (see Conn. Gen. Stat § 17b-259b(a)) of a Short Acting Opioid or Long Acting Opioid for this patient. Submit request, via email, to rx.lmn@ct.gov.**

**If you answered 'YES' to all of the questions above, please fax the completed form to the Gainwell Technologies Pharmacy PA Assistance Center at the number listed at the top of this form.**

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1-13 and 4a-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the client is under my clinic's/practice's ongoing care. I certify that I am a practitioner and hold a current, unrestricted license that allows me to prescribe medication and that I am enrolled in the CT Medical Assistance Program.

**Prescriber Signature: _____ Date: _____**

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