**TO: Pharmacy Providers, Physicians, Nurse Practitioners, Physician Assistants, Clinics, Long Term Care Providers, and Hospitals**

**RE: New Prior Authorization Request Form for Long Acting Sustained Release Opioid Medications**

Effective December 1, 2016, Prior Authorization (PA) will be required for long acting sustained release opioid medications for HUSKY A, HUSKY B, HUSKY C, HUSKY D, FAMPL and TB clients.

Prescribing providers who are actively enrolled in the Connecticut Medical Assistance Program (CMAP) with the following taxonomies will be excluded from the PA requirement:

- 207RH0000X – Physician Hematology
- 207RH0003X – Allopathic & Osteopathic Physicians/Internal Medicine, Hematology & Oncology
- 207RX0202X – Allopathic & Osteopathic Physicians/Internal Medicine, Medical Oncology
- 2080P0207X – Physician Pediatrics – Pediatric Hematology/Oncology

**Please note:** Patients currently receiving long acting opioid medications will be exempt from the PA requirement for a period of six (6) months. This 6 month grace period is to allow time for the prescriber to re-evaluate clients currently receiving long acting sustained release opioid medications and the need for using these medications going forward.

**Prior Authorization (PA) Requirements**

In order to receive PA for long acting opioid medications, the following criteria must be met:

1. The patient must be age 12 or older;
2. The patient must have a diagnosis of cancer;
3. The patient must be under the care of an Oncologist or Pain Specialist experienced in the use of Schedule II opioids to treat cancer pain;
4. The patient does not have any of the following contraindications:
   - hypersensitivity to opiates,
   - hypoxia/hypercarbia,
   - severe asthma or chronic obstructive pulmonary disease, or
   - paralytic ileus.
5. The patient needs an ongoing, continuous course of therapy and not on an as needed basis.

In instances where the individual does not meet all five (5) criteria, the prescriber may write a letter of medical necessity to the Department's Medical Director for consideration. Letters of medical necessity should be faxed alongside the Long Acting Sustained Release Opioid PA Form to (860) 424-4822.

As a reminder, effective 07/1/2016, section 7 of Public Act 16-43 prohibits a prescribing provider from issuing a prescription for more than a seven day supply with limited exceptions. All practitioners who prescribe greater than a seventy-two hour supply of any controlled substance (Schedule II-V) are required to review the patient's records in the Connecticut Prescription Monitoring and Reporting System (CPMRS) at https://connecticut.pmpaware.net. The full requirements are discussed in Provider Bulletin PB 16-36, released on 06/20/2016.

The new Long Acting Sustained Release Opioid PA Form is attached below and will be available on the www.ctdssmap.com Web site. From the

Home page, go to Information > Publications > Authorization/Certification Forms > Long Acting Sustained Release Opioid PA Form; or from the Home page, go to Pharmacy Information > Pharmacy Program Publications > Long Acting Sustained Release Opioid PA Form.

The Pharmacy Web PA feature available on the www.ctdssmap.com secure Web portal will be updated in order to allow prescribing providers to submit long acting sustained release opioid PA requests in the near future.

**STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES**
**TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110 OR (860) 269-2035**

## CT Medical Assistance Program
## Long Acting Sustained Release 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. Please fax the completed form to the Hewlett Packard Enterprise Pharmacy PA Assistance Center at the number above for evaluation & processing.**

# Clinical Information

| | |
|---|---|
| Is the patient 12 years of age or older? | □ Yes □ No |
| Does the patient have a diagnosis of cancer? | □ Yes □ No |
| Is the patient under the care of an Oncologist or pain specialist who is experienced in the use of Schedule II opioids to treat cancer pain? | □ Yes □ No |
| Is the patient free from all of the following contraindications: hypersensitivity to opiates, hypoxia/hypercarbia, severe asthma or chronic obstructive pulmonary disease, or paralytic ileus? | □ Yes □ No |
| The patient needs an ongoing, continuous course of therapy and not on an as needed basis. | □ Yes □ No |

***If you answered 'NO' to any of the questions above, this request must be reviewed by the Medical Director for consideration. Please provide additional information relating to the medical necessity (see Conn. Gen. Stat. § 17b-259b(a)) of a Long Acting Sustained Release Opioid for this patient. Submit request, via fax, to 860-424-4822.**

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**If the medication being requested is a Non-Preferred Drug, one of the following reasons for not using a Preferred Drug must be indicated:**

- ☐ Intolerance to preferred agents
- ☐ Adverse reaction to preferred agent
- ☐ Inadequate response to preferred agents
- ☐ Absence of appropriate formulations
- ☐ Medically necessary/medically appropriate

**Preferred Long Acting Opiates:**

**Fentanyl (12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr), Hysingla ER, Methadone, Morphine ER Tablet, Tramadol ER (generic Ultram ER)**

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:_____**