1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

# Xtampza ER® Long-Acting Opioid Prior Authorization Request Form (Page 1 of 3)

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information (required) | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**For states, such as AR, that have a terminal illness mandate, and for patients who have a terminal illness, please answer the following:**

Will the requested medication be used for the treatment of a terminal condition or associated symptoms? ❑ **Yes** ❑ **No**

If "**YES**", please indicate the patient's estimated life expectancy: ❑ Less than 6 months ❑ Less than_____months (please specify)

**Please answer the following:**

Is the patient **currently** established on the requested long-acting opioid? ❑ **Yes** ❑ **No**

Is the patient new to ProAct Insurance (as evidenced by coverage effective date of less than or equal to 120 days)? ❑ **Yes** ❑ **No Select all the applicable diagnoses below :**

❑ Cancer or end of life related pain
❑ Moderate to severe chronic pain that is non-neuropathic
❑ Moderate to severe neuropathic pain or fibromyalgia (examples of neuropathic pain include neuralgias, neuropathies)
❑ Other diagnosis: _____

**For diagnosis of cancer or end of life (defined as a < 2 years life expectancy) related pain, please answer the following:**

Does the patient have an active cancer diagnosis or life expectancy of < 2 years? ❑ **Yes** ❑ **No**

Will medical records documenting an active cancer diagnosis or life expectancy of < 2 years be submitted to *ProAct*® with this fax form? ❑ **Yes** ❑ **No**

****Please note: Medical records documenting an active cancer diagnosis or life expectancy of < 2 years is required to be submitted along with this fax form. ****

**For diagnosis of moderate to severe chronic pain that is non-neuropathic, please answer the following:**

Is the requested medication being used as an as-needed (PRN) analgesic? ❑ **Yes** ❑ **No**

Is the requested medication being used for pain that is mild or not expected to persist for an extended period of time? ❑ **Yes** ❑ **No**

Is the requested medication being used for acute pain? ❑ **Yes** ❑ **No**

Is the requested medication being used for postoperative pain? ❑ **Yes** ❑ **No** If **yes**, please answer the following:

- Has the patient already received chronic opioid therapy prior to surgery or is the postoperative pain expected to be moderate to severe and persist for an extended period of time? ❑ **Yes** ❑ **No**

Prior to the start of therapy with the requested long-acting opioid, has the patient failed an adequate trial of a short-acting opioid? ❑ **Yes** ❑ **No**

If **yes**, please document the name of the medication(s), date, and duration of trial:

Medication:_____ Date of trial:_____ Duration of trial: _____

PRO ACT PHARMACY BENEFIT MANAGEMENT

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**For diagnosis of moderate to severe neuropathic pain or fibromyalgia, please answer the following:**

Does the patient have a contraindication to or has not exhibited an adequate response to treatment with gabapentin titrated to a therapeutic dose? ❑ **Yes** ❑ **No** If **yes**, please document dose, date, and duration of trial

Dose:_____ Date of trial:_____ Duration of trial: _____

Does the patient have a contraindication to or has not exhibited an adequate response to treatment with a tricyclic antidepressant titrated to the maximum tolerated dose? ❑ **Yes** ❑ **No** If **yes**, please document drug, dose, date, and duration of trial:

Medication:_____Dose:_____ Date of trial:_____ Duration of trial: _____

**Clinical information [Non-cancer and non-end of life pain only]:**

1. What are the treatment goals for this patient? (Document treatment goals) _____
2. What alternative nonopioid analgesic and/or nonpharmacologic interventions are currently being used with this requested medication? (Document other treatment interventions) _____
3. Has the patient demonstrated meaningful improvement in pain scale score? (Document score) ❑ **Yes** ❑ **No** _____
4. What is the patient's most recent score on a substance abuse/opioid dependence risk assessment tool? (Document score) _____
5. What is the rationale for not tapering and discontinuing the requested medication? (Document rationale) _____
6. What comorbid mental health conditions has the patient been screened for? (Document mental health conditions for which the patient has been screened) _____
7. Has the state's prescription drug monitoring program (PDMP) been reviewed for this patient? ❑ **Yes** ❑ **No** ❑ **None in state**
   What other controlled substances is the patient currently receiving? _____
8. Has the patient been assessed for risk of respiratory depression from medical comorbidities or the concurrent use of benzodiazepines or other drugs causing drug-drug interactions and the prescriber acknowledges that they have completed an assessment of increased risk for respiratory depression? ❑ **Yes** ❑ **No**_____
9. What is the patient's total daily dose? _____

**Select the medications the patient has a history of failure, contraindication, or intolerance to:**

❑ Embeda (morphine sulfate and naltrexone hydrochloride)
❑ Hydromorphone extended-release (ER)
❑ Morphine sulfate ER
❑ Oxycontin (oxycodone hydrochloride)
❑ Oxymorphone ER

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**Quantity limit requests:**

What is the quantity requested per DAY? _____

**For diagnosis of cancer related pain or who are end of life (life expectancy < 2 years), please answer the following:**

Can the requested dose be achieved by moving to a higher strength dosage form? ❑ **Yes** ❑ **No**

**For diagnosis of non-cancer or non-end of life related pain, please answer the following:**

Does the requested dose exceed 90 morphine equivalent doses (MED) daily? ❑ **Yes** ❑ **No**

**Example of 90 MED equivalent: Xtampza ER = 54mg/day**

Can the requested dose be achieved by moving to a higher strength dosage form? ❑ **Yes** ❑ **No**

**What is the reason for exceeding the plan limitations?**

❑ Titration or loading-dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

**Prescriber attestation:**

Does the prescriber attest that the information provided is true and accurate to the best of their knowledge and understand that ProAct may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided? ❑ **Yes** ❑ **No**

Prescriber's signature: _____ Date: _____

**Please note: All information must be completed and chart documentation (i.e., chart notes) [where applicable] must be submitted to ProAct.**

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

Please note: This request may be denied unless all required information is received.

**Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.**

**Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.**

**I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.**

**Provider/Representative (and Title): _____ Date: _____**

| **PROACT INTERNAL USE ONLY:** | | | | | |
|---|---|---|---|---|---|
| **Clinical Review Decision** | | | | | |
| | **Approved, through** | | | | |
| | **Denied (documentation attached, if necessary)** | | | | |
| **Tracking:** | | | | | |
| 1st Attempt | | 2nd Attempt | | Letter Mailed: | |