

**State of Idaho, Division of Medicaid
NARCOTIC ANALGESICS, LONG ACTING
*CONFIDENTIAL INFORMATION***

Phone: 1-208-364-1829

One drug per form ONLY – Use black or blue ink

Fax: 1-208-364-1864

Patient Name: _____	Medicaid ID#: _____	Date of Birth: _____
Prescriber Name: _____	State License #: _____	Specialty: _____
Prescriber Phone: _____	Prescriber Fax: _____	
Pharmacy/Store#: _____	Phone: _____	Fax: _____

Kadian®, methadone, and morphine sulfate generic (extended release) are approved for payment without prior authorization for eligible participants within approved dosage quantities and age limits.

Avinza®, Duragesic®, MS Contin®, Oramorph®, oxycodone (extended release), OxyContin®, and Opana ER® will be approved for payment only after a minimum 30 day trial period and documented failure of a preferred agent in the past 6 months.

Duragesic® is preferred over generic fentanyl patches & will be authorized if one or more of the following criteria are met:

- Documented trial and failure of preferred agent as outlined above.
- Participant is unable to take oral medications.
- Participant is age 65 or older.
- Participant is allergic to morphine or methadone.

Participants with a diagnosis of cancer or history of chemotherapy in the past 12 months will be exempt from the prior authorization criteria.

Long Acting Opioid Requested

Morphine Sulfate (extended release)	NO PA REQUIRED
Methadone	NO PA REQUIRED
Kadian®	NO PA REQUIRED

<u>Drug</u>	<u>Strength</u>	<u>Instructions</u>
<input type="checkbox"/> Avinza®	_____	_____
<input type="checkbox"/> Duragesic®	_____	_____
<input type="checkbox"/> Fentanyl patches	_____	_____
<input type="checkbox"/> MS Contin®	_____	_____
<input type="checkbox"/> Opana ER®	_____	_____
<input type="checkbox"/> Oxycodone HCl long-acting	_____	_____
<input type="checkbox"/> Oramorph®	_____	_____
<input type="checkbox"/> OxyContin®	_____	_____

Drug Allergies: _____

Is the participant currently being treated for cancer? Yes, ICD-9 = _____ No

History of Other Long-Acting Opioid Trials and Reason for Failure:

Prescriber Signature: _____ **Date:** _____

By signing, the prescriber agrees that documentation of above indication and medical necessity is available for review by Idaho Medicaid in patient's current medical chart.

For Medicaid Office Use Only			
Date	RPh	Tech	PA#
Approved	Denied	Comments:	

All current PA forms and criteria for use are available at: <http://www.medicaidpharmacy.idaho.gov> (PA Criteria & Forms)