**State of Maine Department of Health &Human Services**
**MaineCare/MEDEL Prior Authorization Form**
# OPIATE LIMITS PA

Phone: 1-888-445-0497 **www.mainecarepdl.org** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

Patient Address: _____

Provider DEA: |__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name: _____ Phone: _____

Provider Address: _____ Fax: _____

Pharmacy Name: _____Rx Address:_____Rx phone:_____

**Provider must fill all information above. It must be legible, correct and complete or form will be returned.**

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

**Prior authorization is not required for preferred medication for members in a nursing facility, hospice care and members receiving opioids for symptoms of Cancer or HIV/AIDS. Prior authorization will also not be required for members using 30mg or less MSE per day and ≤ 7days supply. Please refer to mainecarepdl.org for additional criteria including MSE conversion limitations.**

| Drug Name | Strength | Dosage Instructions | Quantity | Days Supply (34 retail) |
|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ |

## Medical Necessity Documentation Required:

**(Required Attachments: supporting chart notes, medical diagnosis and proper opiate monitoring)**

Why is this medication necessary for this member?

_____

_____

## Acute Pain:

Have you diagnosed this patient with acute pain? Yes No

If the PA is for a long acting narcotic, please explain why it is medically necessary to treat short-term acute pain? _____

_____

## Chronic Pain: (non-acute only)

Have you diagnosed this patient with long-term non-acute (Chronic Pain)? Yes No

Is the patient currently participating in one of the covered treatment options? Yes No
(PT, OMT, CBT, Acceptance Commitment Therapy)

If yes which one? _____
If no when is the first appointment? _____

Is this PA intended to authorize opioid medications for treatment of headache, back pain, neck pain or fibromyalgia? Yes No

**If yes, please attach second opinion note recommending that opioids be used as part of a Pain Management Plan for this patient.**

If this PA request is for more than 300mg of morphine sulfate equivalent (MSE) per day, please state the timeframe for tapering down to 100mg or less of morphine sulfate equivalent. _____

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ Date of Submission: _____
***MUST MATCH PROVIDER LISTED ABOVE**