GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Please note: All information below is required to process this request.
Mon-Fri: 8am to 1am Eastern / Sat: 9am to 6pm Eastern

Exceeding Morphine Milligram Equivalent (MME) Maximums Prior Authorization Request Form (Page 1 of 2)

Note: If the following information is NOT filled in completely, correctly, or legibly the PA process **may** be delayed.

Please complete one form per member.

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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)

Please check all that apply and provide all applicable information.

Section A: If the member meets one of the following then Section B is not required

Select if the member is receiving opioid for the following:

- ◯ Active cancer treatment. Cancer type: _____
- ◯ Hospice. Diagnosis: _____
- ◯ Long-term care/skilled nursing facility
- ◯ Palliative care (diagnosis code Z51.5). Diagnosis: _____
- ◯ Sickle cell disease

Section B: For members not meeting one of the criteria under Section A

Does the member have a diagnosis requiring around-the-clock pain management? ◯ **Yes** ◯ **No**

Provide the diagnosis: _____

Has the provider reviewed controlled substance prescriptions in the prescription drug monitoring program? ◯ **Yes** ◯ **No**

Please select and provide the pain management specialist's information below:*

- ◯ Regimen **prescribed by** a pain management specialist within last 6 months
  - Specialist's name: _____
  - Date of last visit: _____
- ◯ Regimen **prescribed in consultation** with a pain management specialist within last 6 months
  - Specialist's name: _____
  - Date of last consultation: _____

**Please note: Physician must be Board Certified by one of the following:*

1. *American Board of Anesthesiology-Pain Management*
2. *American Board of Psychiatry & Neurology-Pain Management*
3. *American Board of Physical Medicine & Rehabilitation*
4. *American Osteopathic Association-Pain Management*

< continued on the next page >

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Exceeding Morphine Milligram Equivalent (MME) Maximums Prior Authorization Request Form (Page 2 of 2)

< continued from the previous page >

Is the member-prescriber pain management/opioid agreement/contract signed within one year of request and is in medical record? ◯ **Yes** ◯ **No**

Please select dose attestation:

- ◯ Dose reduction is planned
- ◯ Dose reduction has occurred since previous prior approval.
  - Previous Dose: _____
  - New Dose: _____
- ◯ There is documentation of an attempted unsuccessful dose taper within the past 6 months.
  - Taper Date: _____
- ◯ Provider attests that a dose taper is not clinically appropriate for this member

Has or will the member have random urine drug screens? ◯ **Yes** ◯ **No**

Was naloxone prescription provided or offered to member/member's household? ◯ **Yes** ◯ **No**

I certify that the benefits of opioid treatment for this member outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Physician Signature (required): _____ Date:_____

Physician Office Contact Person: _____ Phone: _____

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.
For urgent or expedited requests please call 1-866-525-5827.
This form may be used for non-urgent requests and faxed to 1-877-239-4565.