BlueCross BlueShield Federal Employee Program.

METHADONE PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

*****The CDC's Opioid Guideline Mobile App is designed to help providers with Morphine Milligram Equivalent (MME) calculations when prescribing opioids. The CDC app is available for free download on Google Play for Android devices and in the Apple Store for iOS devices*****

NOTE: Form must be completed in its **entirety** for processing

Please select the prescribed form:

❑Dolophine 5mg tablet	**❑Methadone 40mg tablet**	**❑Methadone 10mg/5mL oral solution**
❑Dolophine 10mg tablet	**❑Methadone 5mg/5mL oral solution**	**❑Methadose/Methadone Intensol 10mg/mL oral concentrate**

*****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's total MME per day? ***Please select answer below:***
   ❑200 MME per day or less ***(please specify all opioids)***: _____
   ❑Greater than 200 MME per day ***(please specify all opioids)***: _____

2. Is this medication being used to treat any of the following: pain associated with cancer or prescribed by a board-certified oncologist, pain associated with sickle cell disease, **OR** treatment associated with hospice, palliative, or end-of-life care? ❑Yes***** ❑No
   ****If YES***, please select one of the following below:
   ❑Pain associated with sickle cell disease ❑Treatment associated with hospice, palliative, or end-of-life care
   ❑Pain associated with cancer or prescribed by a board-certified oncologist

3. Will the patient be using methadone concurrently with Lucemyra or a buprenorphine medication such as Suboxone for opioid addiction? ❑Buprenorphine medication for opioid addiction ❑Lucemyra ❑No

4. Will the patient be taking another opioid, either long acting (ER/LA/SA) or immediate acting (IR), with the methadone? ❑Yes***** ❑No

5. What is the patient's diagnosis? ***Please select answer below:***
   ❑Opioid addiction
   a. Is the patient taking methadone exclusively for pain control? ❑Yes ❑No
   b. Has the patient been on this medication continuously for the last **4 months** excluding samples? ❑Yes ❑No*****
   ****If NO***, please answer the following questions:
   i. Does the patient have opioid addiction requiring detoxification treatment? ❑Yes ❑No
   ii. Will the patient be monitored during therapy for signs and symptoms of abuse/misuse as well as compliance and the potential diversion to others? ❑Yes ❑No
   c. Does the patient have opioid addiction requiring maintenance treatment in conjunction with appropriate social and medical services? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Pain

a. Does the physician agree to assess the patient for signs and symptoms of serotonin syndrome? ❑Yes ❑No

b. Does the prescriber agree to participate in the *****Opioid Analgesic REMS program **AND** to monitor for abuse, misuse, addiction, and overdose and discontinue if necessary? ❑Yes ❑No

Opioid Analgesic REMS Program: **https://opioidanalgesicrems.com**

c. Does the prescriber agree to evaluate the patient's response to therapy before changing dose? ❑Yes ❑No

d. Has the patient been on this medication continuously for the last **4 months** excluding samples? ❑Yes ❑No*****

****If NO***, have alternative treatments, including non-opioid analgesics and other immediate-release opioids, been ineffective, not tolerated, or inadequate at controlling the patient's pain? ❑Yes ❑No

e. Does the prescriber agree to continue to assess the patient for the benefits of pain control, for example, by implementing a care plan, monitoring for signs of misuse/abuse using standard lab screening (i.e. urine, blood), and evaluating severity of pain after 3 months of therapy? ❑Yes ❑No

f. Will the patient be using this medication in combination with alprazolam (Xanax), clonazepam (Klonopin), diazepam (Valium), or lorazepam (Ativan)? ❑Yes ❑No

g. Will the patient be using this medication in combination with oxazepam (Serax), chlordiazepoxide (Librium), or clorazepate dipotassium (Tranxene)? ❑Yes ❑No

❑None of the above

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Methadone – FEP MD Fax Form Revised 1/12/2024