Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Healthcare Programs Prior Authorization Request Form for Use of Methadone in the Treatment of Non-Malignant Pain

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Requested Dose and Directions (*Note: authorization will only be granted for use on a **scheduled basis***):		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

- Member is ≥18 years of age: ☐ Yes ☐ No
- Methadone is being prescribed for the treatment of severe, chronic pain only. ☐ Yes ☐ No
- Member is opioid tolerant (within the last 2 weeks member has received opioid analgesics at the following minimum total daily doses for at least 1 week), i.e., ☐ 60 mg oral morphine ☐ 25 mcg/hr transdermal fentanyl
  ☐ 30 mg oral oxycodone ☐ 8 mg oral hydromorphone ☐ 25 mg oral oxymorphone
- Member has trialed at least *two* preferred, long-acting opioid agents within the last 6 months:
  ☐ Butrans® patch ☐ Morphine Sulfate SR tab
- Provider has completed an initial urine drug screen. ☐ Yes ☐ No
- The following required documentation is attached:
  ☐ All chart notes supporting a diagnosis of severe, chronic pain.
  ☐ A copy of the signed pain management agreement (including monitoring plan, i.e., drug screens, pill counts, Prescription Drug Registry (PDR) review plan, realistic goals for pain and function, etc.)
  ☐ A copy of the PDR report for the last 3 months
  ☐ **A copy of the signed Methadone Safety Screening Form (page 2)**

Link to methadone dosing guidance: http://www.jpain.org/article/S1526-5900(14)00522-7/fulltext

LIMITATIONS:
- Duplication with other long-acting opioids or benzodiazepines will not be allowed.
- Max total daily dose authorized = 80 mg (dose optimization required).

Initial authorization will be issued for 6 months.

☐ CONTINUATION OF THERAPY

- Member has been compliant with all medication fills: ☐ Yes ☐ No
- Provider attests member has not filled opiates/benzodiazepines from any other prescriber: ☐ Yes ☐ No
- No history of behavior indicative of substance abuse has been noted (repeat urine drug screens, early fills, PDR review, etc.): ☐ Yes ☐ No

Reauthorization will be issued for 12 months.

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit at 1-800-294-1350

Methadone Safety Screening Form

Rationale for Safety Screening: Methadone contributes disproportionately to overdose compared to other opioid pain relievers. *Approximately 1 out of 3 opioid-related deaths is associated with methadone ingestion.*

Provider attests to the following (please check ☐):

- ☐ **An individualized medical/ behavioral risk evaluation has been performed to assess risks (abuse, addiction, diversion, overdose and adverse drug reactions) and benefits of methadone use in this member.**
- ☐ **An overdose/poisoning/oversedation plan will be discussed with the member and naloxone rescue therapy considered.**
- ☐ **Member has been informed of the risk of arrhythmia and screened to identify the risk of prolonged QTc:**
  - Presence of hypokalemia or hypomagnesemia.
  - Structural heart disease (congenital heart defects, history of endocarditis or heart failure).
  - Genetic predisposition (congenital prolonged QT syndrome or familial history of prolonged QT syndrome).
  - Significant liver disease (Child Pugh Class B/C).
  - Use of other medications with QTc prolonging properties or CYP3A4 inhibitors. Resources: (https://crediblemeds.org/healthcare-providers/) and (http://medicine.iupui.edu/clinpharm/ddis/clinical-table//).
  - Methadone dose > 40 mg/day.

If **yes** to any of the above check boxes **or** prior ECG w/QTc >450 ms **or** history suggestive of prior ventricular arrhythmia (i.e. prior cardiac arrest, unexplained syncope or seizure).

- Obtain pretreatment ECG to measure baseline QTc interval (ECG within last 3 months with no new risks is acceptable).
- Perform follow-up ECGs within 2-4 weeks after initiating therapy and with any significant dose increase.

If **no** to any of the above:

- Consider a baseline ECG. ECG within last 12 months is sufficient.
- Perform follow-up ECG when methadone dose reaches 30-40 mg/day or presence of new risk factors for QTc prolongation or arrhythmia signs/symptoms.

Assessing QTc Interval

- **QTc interval <450 ms:** Considered normal. Obtain repeat ECG if dose is increased significantly, if member develops sign/symptoms of QTc prolongation, or if QT prolonging drug is added to therapy.
- **QTc interval 450-500 ms:** Consider switch to alternative opioid or dose reduction. Discuss potential risks with member if methadone continued. Evaluate and correct reversible causes of QTc prolongation. Repeat ECG after methadone dose has been decreased.
- **QTc interval > 500 ms:** ***Methadone initiation not recommended.*** Immediately reduce dose if currently on methadone. Evaluate and correct reversible causes of QTc prolongation. Repeat ECG after methadone dose has been decreased.

Signature of Physician: _____ Date: _____

References:

1. Centers for Disease Control and Prevention: Vital signs: Risk for overdose from methadone used for pain relief-United States, 1999-2010. MMWR Morb Mortal Wkly Rep 61: 493-497. 2012.
2. Methadone Safety: A Clinical Practice Guideline From the American Pain Society and College on Problems of Drug Dependence, in Collaboration With the Heart Rhythm Society.Chou, Roger et al. The Journal of Pain , Volume 15 , Issue 4 , 321 – 337.

Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain = 3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1– 4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled = 3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If = 50 MME/day total (= 50 mg hydrocodone; = 33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid = 90 MME/day total (= 90 mg hydrocodone; = 60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (= 3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (PDMP): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

Q1: *What number from 0-10 best describes your **pain** in the past week?*
0 = "no pain", 10 = "worst you can imagine"

Q2: *What number from 0-10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0 = "not at all", 10 = "complete interference"

Q3: *What number from 0-10 describes how, during the past week, pain has interfered with your **general activity**?*
0 = "not at all", 10 = "complete interference"

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

TO LEARN MORE
www.cdc.gov/drugoverdose/prescribing/guideline.html

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