

BENZODIAZEPINE AND OPIOID CONCURRENT THERAPY PRIOR AUTHORIZATION REQUEST FORM



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Today's Date

/ /

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be rejected****

Patient's Medicaid # <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>
Patient's Name	Prescriber's Name
Prescriber's IN License # <input type="text"/>	Specialty
Prescriber's NPI # <input type="text"/>	Prescriber's Signature: **required below within attestation section**
Return Fax # <input type="text"/> - <input type="text"/> - <input type="text"/>	Return Phone # <input type="text"/> - <input type="text"/> - <input type="text"/>
Check box if requesting retro-active PA <input type="checkbox"/>	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

PA is required for the following:

- **Claim(s) for new opioid(s) to be used concurrently with benzodiazepines and exceeding 7 days within a 180-day period**
- **Claim(s) for new benzodiazepine(s) to be used concurrently with opioids and exceeding 7 days of therapy within a 180-day period and/or exceeding established benzodiazepine/opioid concurrent therapy quantity limits (see Sedative Hypnotics Benzodiazepine PA criteria).**

Benzodiazepine Agent(s)	Prescriber Name	Quantity	Dosage Regimen/Duration

Opioid Agent(s)	Prescriber Name	Quantity	Dosage Regimen/Duration

***NOTE: If prescribers of the opioids and benzodiazepines are not the same, please answer the following questions:**

- Are you requesting PA for: Benzodiazepine Agent(s) Opioid Agent(s) Both
- Is/are the other prescriber(s) aware of the request for concurrent therapy? Yes No
- Has the other prescriber been consulted about the risk associated with concurrent therapy, and do all prescribers involved believe continuing with concurrent therapy is warranted, given the risks associated with concurrent use? Yes No

PA Requirements:

Member diagnosis(es) for use of benzodiazepine therapy:

Prior therapies attempted for the above diagnosis(es):

Drug Therapy	Dosage Regimen	Dates of Utilization

Do you plan to continue benzodiazepine therapy for this member? Yes No
If no, please provide withdrawal plan:

Member diagnosis(es) for use of opioid therapy:

Prior therapies attempted for the above diagnosis(es):

Drug Therapy	Dosage Regimen	Dates of Utilization	Reason for Discontinuation

Do you plan to continue opioid therapy for this member? Yes No
If no, please provide withdrawal plan:

Attestation:

I, _____, hereby attest to the following:
(Prescriber Name)

- The member's INSPECT report has been evaluated and continues to be evaluated on a regular basis (per IC 35-48-7-11.1, DO NOT attach a copy of the INSPECT report to this PA request)
- I have educated the member in regards to the risks of concurrent utilization of benzodiazepine and opioid therapy, and the member accepts these risks
- If applicable, I have consulted other prescribers involved in concurrent therapy and all prescribers involved agree to pursue concurrent opioid and benzodiazepine therapy for this member
- I acknowledge, as the prescriber initiating or maintaining concurrent benzodiazepine and opioid therapy, the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization

Prescriber Signature: _____

****Prescriber signature is required for consideration. Electronic or stamped signature will not be accepted****

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