

**INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
BENZODIAZEPINE AND OPIOID CONCURRENT THERAPY
PRIOR AUTHORIZATION (PA) REQUEST FORM**



CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: 866-930-0019



Today's Date

/ /

Non-Urgent ☐

Urgent ☐

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

*****All sections must be completed or the request will be returned.*****

Member's CareSource ID	Member's Date of Birth <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Member's Name	Prescriber's Name
Prescriber's Indiana License Number	Specialty
Prescriber's NPI	Office Contact
Prescriber's Fax <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Prescriber's Phone <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Prescriber's Address	Date(s) of Service:
	Start Date:
	Prescriber's DEA

PA is required for the following:

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

Benzodiazepines and Strengths	Prescriber Name	Quantity	Directions for Use/Duration
Opioids and Strengths	Prescriber Name	Quantity	Directions for Use/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 for use of benzodiazepine therapy:

Member diagnosis(es) for use of benzodiazepine therapy: _____

Diagnosis Code(s): _____

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:

PA Requirements for use of benzodiazepine therapy:

Member diagnosis(es) for use of opioid therapy: _____

Diagnosis Code(s): _____

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: _____ **Date** _____

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

CONFIDENTIAL INFORMATION

This facsimile and any attached document are confidential and are intended for the use of individual or entity to which it is addressed. If you have received this in error, please notify us by telephone immediately at **1-844-607-2831**.