Opioid Toolkit for Dental Providers

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Primary Care "Warm Handoff": For Substance Use Disorder

MODULE 5

www.pa.gov/collections/opioid-epidemic | RA-DH-PDMP@pa.gov

Primary Care Site Preparation[a]

↓

Patient Presents

↓

1. **Medical history/PDMP query**
2. **Physical examination**
3. **Standardized screen for substance use disorder/opioid use disorder[b]**

Screen Positive[c]

↓

Does you practice provide substance disorder treatment?[e]

- ↓ **Yes, begin treatment**
- ↓ **No**

↓

Provide patient-centered communication regarding need to link to substance use disorder treatment system for further support
https://apps.ddap.pa.gov/gethelpnow/CareProvider.aspx

↓

Refer patient to treatment

↓

Contact Single County Authority (Central Intake Unit) for assessment
https://apps.ddap.pa.gov/gethelpnow/CountyServices.aspx

↓

- **Provide transportation**
- **Reach out and make appointments**

Facilitate appointment at an opioid use disorder treatment provider such as a Centers of Excellence
http://www.dhs.pa.gov/citizens/su bstanceabuseservices/centersofexcellence

↓

Provide:
- **Naloxone kits[g]**
- **Naloxone education**
- **Naloxone prescription**

Screen Negative[d]

↓

Provide positive reinforcement[f]

[a] Prepare for managing patients with substance use or opioid use disorder *(see steps 1-10 on pages 8-9 of the Module 5 Guide document)*.

[b] Assess risk for possible substance use disorder using recommended screening tools and conduct laboratory testing (if necessary): liver function/enzyme test, multi-panel blood test, and urine, saliva, or hair drug test.

[c] Positive screen: patient is showing signs of substance use disorder after a PDMP query (i.e., multiple provider episodes), physical examination (i.e., exhibiting symptoms of withdrawal), or standardized screening (i.e., positive results of questionnaire). If the patient presents with one or more of these criteria during screening, then a brief intervention should be conducted to determine appropriate subsequent care services *(refer to Module 6 on Screening, Brief Intervention, and Referral to Treatment).*

[d] Negative screen: patient shows no signs of substance use disorder during assessment

[e] Assess need for detoxification: consider results of substance use disorder screening tools, consider results of laboratory testing, and conduct withdrawal screening using the Clinical Opiate Withdrawal Scale or the Subjective Opiate Withdrawal Scale *(see Module 7 for more information on withdrawal scales).*

[f] Reinforce healthy behavior(s) through positive reinforcement.

[g] If naloxone kits are not available, patients should be provided with a naloxone prescription and should also be informed that the naloxone standing order allows the patient to obtain naloxone without a prescription, if needed.

AUDIT

Introduction

The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organization (WHO) to assess alcohol consumption, drinking behaviors, and alcohol-related problems. Both a clinician-administered version (page 1) and a self-report version of the AUDIT (page 2) are provided. Patients should be encouraged to answer the AUDIT questions in terms of standard drinks. A chart illustrating the approximate number of standard drinks in different alcohol beverages is included for reference. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. The AUDIT has been validated across genders and in a wide range of racial/ethnic groups and is well-suited for use in primary care settings. Detailed guidelines about use of the AUDIT have been published by the WHO and are available online: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

The Alcohol Use Disorders Identification Test: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?
   (0) Never [Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

   Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

STANDARD DRINK EQUIVALENTS	APPROXIMATE NUMBER OF STANDARD DRINKS IN:
BEER or COOLER	
12 oz. **~5% alcohol**	12 oz. = 1 16 oz. = 1.3 22 oz. = 2 40 oz. = 3.3
MALT LIQUOR	
8-9 oz. **~7% alcohol**	12 oz. = 1.5 16 oz. = 2 22 oz. = 2.5 40 oz. = 4.5
TABLE WINE	
5 oz. **~12% alcohol**	
80 proof SPIRITS (hard liquor)	
1.5 oz. **~40% alcohol**	a mixed drink = 1 or more* a pint (16 oz.) = 11 a fifth (25 oz.) = 17 1.75 L (59 oz.) = 39 *Note: Depending on factors such as the type of spirits and the recipe, one mixed drink can contain from one to three or more standard drinks.

http://pubs.niaaa.nih.gov/publications/Practitioner/pocketguide/pocket_guide2.htm

The CRAFFT Screening Interview

Begin: "I'm going to ask you a few questions that I ask all my patients. Please be honest. I will keep your answers confidential."

Part A

During the PAST 12 MONTHS, did you:	**No**	**Yes**
1. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)	☐	☐
2. Smoke any marijuana or hashish?	☐	☐
3. Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")	☐	☐

For clinic use only: Did the patient answer "yes" to any questions in Part A?

No ☐ → **Ask CAR question only, then stop**

Yes ☐ → **Ask all 6 CRAFFT questions**

Part B

	No	**Yes**
1. Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	☐	☐
2. Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	☐	☐
3. Do you ever use alcohol or drugs while you are by yourself, or **ALONE**?	☐	☐
4. Do you ever **FORGET** things you did while using alcohol or drugs?	☐	☐
5. Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	☐	☐
6. Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	☐	☐

CONFIDENTIALITY NOTICE:

The information recorded on this page may be protected by special federal confidentiality rules (42 CFR Part 2), which prohibit disclosure of this information unless authorized by specific written consent. A general authorization for release of medical information is NOT sufficient for this purpose.

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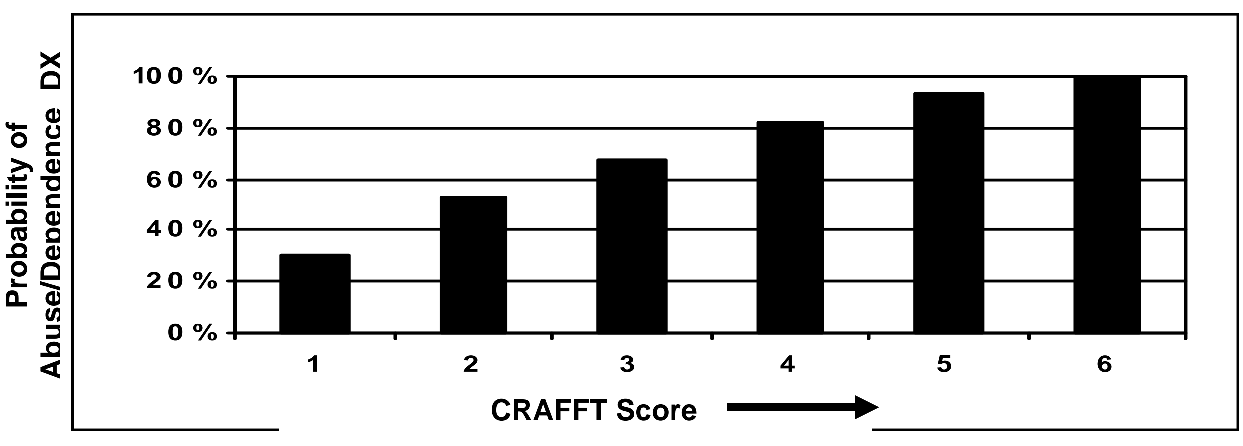
SCORING INSTRUCTIONS: FOR CLINIC STAFF USE ONLY

CRAFFT Scoring: Each "yes" response in **Part B** scores 1 point.
A total score of 2 or higher is a positive screen, indicating a need for additional assessment.

Probability of Substance Abuse/Dependence Diagnosis Based on CRAFFT Score[1,2]



DSM-IV Diagnostic Criteria[3] (Abbreviated)

Substance Abuse (1 or more of the following):

- Use causes failure to fulfill obligations at work, school, or home
- Recurrent use in hazardous situations (e.g. driving)
- Recurrent legal problems
- Continued use despite recurrent problems

Substance Dependence (3 or more of the following):

- Tolerance
- Withdrawal
- Substance taken in larger amount or over longer period of time than planned
- Unsuccessful efforts to cut down or quit
- Great deal of time spent to obtain substance or recover from effect
- Important activities given up because of substance
- Continued use despite harmful consequences

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References:

1. Knight JR, Shrier LA, Bravender TD, Farrell M, Vander Bilt J, Shaffer HJ. A new brief screen for adolescent substance abuse. Arch Pediatr Adolesc Med 1999;153(6):591-6.
2. Knight JR, Sherritt L, Shrier LA, Harris SK, Chang G. Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. Arch Pediatr Adolesc Med 2002;156(6):607-14.
3. American Psychiatric Association. Diagostic and Statistical Manual of Mental Disorders, fourth edition, text revision. Washington DC, American Psychiatric Association, 2000.

OPIOID DEPENDENCE TREATMENTS (ORAL) PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	total # pages:	Name of office contact:
Contact's phone number:		Facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION

Prescriber name:		Specialty:	
State license #:	NPI:	DATA 2000 waiver DEA number:	
Street address:	Suite #:	City/state/zip:	
Phone:		Fax:	

CLINICAL INFORMATION

<u>Preferred</u> drug requested
☐ buprenorphine SL tablet (***clinical prior authorization required)
☐ buprenorphine/naloxone SL film
☐ buprenorphine/naloxone SL tablet

<u>Non-preferred</u> drug requested
☐ Bunavail buccal film
☐ Lucemyra – go to question 9
☐ Suboxone SL film
☐ Zubsolv SL tablet
☐ _______________

Strength:	Directions:	Quantity:	Requested duration:
Diagnosis (submit documentation):		Dx code (required):	

Question	Response	
1. Is the patient being treated for a diagnosis of opioid use disorder?	☐ Yes – Submit documentation of diagnosis. ☐ No – Submit medical literature supporting the use of the requested agent for the diagnosis.	
2. Did the prescriber or prescriber's delegate search the PDMP to review the patient's controlled substance prescription history before issuing this prescription for the requested medication?	☐ Yes ☐ No	*Submit documentation.*
3. For non-preferred requests, does the patient have a history of trial and failure, contraindication, or intolerance of the preferred agent?	☐ Yes – list medications tried:_______________ ☐ No	
4. ***For requests for an oral buprenorphine agent that does not contain naloxone, do any of the following apply to the patient? Check all that apply. ☐ patient is pregnant ☐ patient is breastfeeding ☐ the requested agent is being used for induction therapy	☐ Yes ☐ No	*Submit documentation.*
5. Does the request exceed the daily dose limit of 16 mg of buprenorphine per day?	☐ Yes – Submit documentation supporting requested dose and **continue to question 6**. ☐ No – Skip to question 7.	

6. <u>For requests above the daily dose limit of 16 mg of buprenorphine per day</u>, check all of the following that apply to the patient, <u>submit documentation for each</u>, and **continue to question 7**.
☐ Has an initial or scheduled evaluation by a licensed D&A provider or Single County Authority (SCA) for the determination of level of care
☐ Is participating in a program with a licensed D&A or behavioral health provider at the recommended level of care
☐ Is participating in a substance abuse or behavioral health counseling or treatment program or an addictions recovery program
☐ Has results of a recent UDS (including licit and illicit drugs with abuse potential) demonstrating compliance with oral buprenorphine therapy

7. Is the patient taking a benzodiazepine or other CNS depressant?
☐ Yes – Submit patient's medication list and **continue to question 8**.
☐ No – Submit patient's medication list.

8. <u>For a patient who is taking a benzodiazepine (BZD) or other CNS depressant in addition to the requested buprenorphine agent,</u> check all of the following that apply to the patient and <u>submit documentation for each.</u>
☐ Was educated about the serious risks of concomitant use of buprenorphine with the BZD or other CNS depressant
☐ Has a plan in place to taper the BZD or other CNS depressant
☐ Is receiving the BZD or other CNS depressant for anxiety or insomnia, and this diagnosis was verified
☐ Is receiving the BZD or other CNS depressant for anxiety or insomnia, and other treatment options for the diagnosis were considered
☐ Concomitant use of buprenorphine with the BZD or other CNS depressant is medically necessary
☐ Has results of urine or blood screening

Question	Response	
9. <u>For Lucemyra requests</u>, does the patient have a history of trial and failure, contraindication, or intolerance of **clonidine tablet**?	☐ Yes ☐ No	*Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:

<u>Confidentiality Notice</u>: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.

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OPIOID DEPENDENCE TREATMENTS (ORAL) PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

Fax to PerformRx[SM] at **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	total # pages:	Name of office contact:
Contact's phone number:		Facility contact/phone:

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:		Specialty:
State license #:	NPI:	DATA 2000 waiver DEA number:
Street address:	Suite #:	City/state/zip:
Phone:		Fax:

CLINICAL INFORMATION

<u>Preferred</u> drug requested
- ☐ buprenorphine SL tablet (***clinical prior authorization required)
- ☐ buprenorphine/naloxone SL film
- ☐ buprenorphine/naloxone SL tablet

<u>Non-preferred</u> drug requested
- ☐ Bunavail buccal film
- ☐ Lucemyra – go to question 9
- ☐ Suboxone SL film
- ☐ Zubsolv SL tablet
- ☐ ________________

Strength:	Directions:	Quantity:	Requested duration:
Diagnosis (submit documentation):		Dx code (required):	

Question	Response	
1. Is the patient being treated for a diagnosis of opioid use disorder?	☐ Yes – Submit documentation of diagnosis. ☐ No – Submit medical literature supporting the use of the requested agent for the diagnosis.	
2. Did the prescriber or prescriber's delegate search the PDMP to review the patient's controlled substance prescription history before issuing this prescription for the requested medication?	☐ Yes ☐ No	*Submit documentation.*
3. For non-preferred requests, does the patient have a history of trial and failure, contraindication, or intolerance of the preferred agent?	☐ Yes – list medications tried:________________________ ☐ No	
4. ***For requests for an oral buprenorphine agent that does not contain naloxone, do any of the following apply to the patient? Check all that apply. ☐ patient is pregnant ☐ patient is breastfeeding ☐ the requested agent is being used for induction therapy	☐ Yes ☐ No	*Submit documentation.*
5. Does the request exceed the daily dose limit of 16 mg of buprenorphine per day?	☐ Yes – Submit documentation supporting requested dose and **continue to question 6**. ☐ No – Skip to question 7.	

6. <u>For requests above the daily dose limit of 16 mg of buprenorphine per day</u>, check all of the following that apply to the patient, <u>submit documentation for each</u>, and **continue to question 7**.
   - ☐ Has an initial or scheduled evaluation by a licensed D&A provider or Single County Authority (SCA) for the determination of level of care
   - ☐ Is participating in a program with a licensed D&A or behavioral health provider at the recommended level of care
   - ☐ Is participating in a substance abuse or behavioral health counseling or treatment program or an addictions recovery program
   - ☐ Has results of a recent UDS (including licit and illicit drugs with abuse potential) demonstrating compliance with oral buprenorphine therapy

Question	Response
7. Is the patient taking a benzodiazepine or other CNS depressant?	☐ Yes – Submit patient's medication list and **continue to question 8**. ☐ No – Submit patient's medication list.

8. <u>For a patient who is taking a benzodiazepine (BZD) or other CNS depressant in addition to the requested buprenorphine agent,</u> check all of the following that apply to the patient and <u>submit documentation for each.</u>
   - ☐ Was educated about the serious risks of concomitant use of buprenorphine with the BZD or other CNS depressant
   - ☐ Has a plan in place to taper the BZD or other CNS depressant
   - ☐ Is receiving the BZD or other CNS depressant for anxiety or insomnia, and this diagnosis was verified
   - ☐ Is receiving the BZD or other CNS depressant for anxiety or insomnia, and other treatment options for the diagnosis were considered
   - ☐ Concomitant use of buprenorphine with the BZD or other CNS depressant is medically necessary
   - ☐ Has results of urine or blood screening

Question	Response	
9. <u>For Lucemyra requests</u>, does the patient have a history of trial and failure, contraindication, or intolerance of **clonidine tablet**?	☐ Yes ☐ No	*Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:

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Patient Informed Consent for the Dental Use of Opioid Medication

"Opioids" is the medical name for strong painkillers and like all medications, opioids have specific risks and benefits. The purpose of this Informed Consent Document is to outline those risks and benefits so that together with Dr. ____________________________ you can determine if they are the right pain medication for you to try with your dental procedure. The possible side effects are the same for all the opioids but different people react to each opioid individually.

The risks of using these medications are:

Addiction is a disease that occurs in some individuals. Like becoming overweight does not necessarily mean you will become diabetic, taking opioids does not necessarily cause addiction, however, if you have risk factors for addiction (such as a strong family history of drug or alcohol abuse) or have had problems with drugs or alcohol in the past you must notify me since using opioid painkillers may increase the possibility of relapse of these problems, The extent of this risk is not certain.

- I have notified Dr. _________________________ of any personal or family history of drug or alcohol abuse.

___________ (PATIENT INITIALS)

Physical dependence means that if the opioid medication is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal response to some medications and also occurs, for instance with antidepressants. Stopping opioids can be uncomfortable but not usually dangerous if done with a controlled, gradual approach. I will be giving you a short & controlled period of this medication. Having withdrawal after stopping or reducing prescribed opioids in no way implies that you are addicted. The withdrawal symptoms could include sweating, nervousness, stomach cramps, diarrhea, feeling worried, irritable or moody.

Tolerance means that over time the body becomes "used to" the medication and it feels less effective. The dose of the opioid painkiller may have to be adjusted to a dose that produces maximum benefit and a *realistic* decrease of your pain yet does not have intolerable side effects. Sometimes this is not possible and the opioid painkillers will have to be stopped.

Constipation
Nausea and vomiting
Reduced production of testosterone (may cause reduced libido and fertility in men)
Reduced production of estrogen and progesterone (may cause periods to stop and reduced libido and fertility in women)
Excessive sweating
Weight gain
Swollen angles/legs
Sedation, Drowsiness, Clouded Thinking

- I am aware that drowsiness or clouded thinking may make it dangerous for me to drive or operate heavy machinery. Alcohol or other medications that also cause drowsiness may worsen

this effect, if I take it/them with this medication. I have honestly filled out my "past medical history" and "current medication forms" and have alerted Dr. _______________________to any other medications (legal or otherwise) that I may be taking that would add to the sedation and drowsiness effects of opioid pain medication. I agree not to drive or operate heavy machinery or sign legal documents while I am taking these pain medication, or if I feel in any way impaired from this therapy at other times.

__________ (PATIENT INITIALS)

- I understand that the use of alcohol and opioid medications together is potentially dangerous and I have been advised not to do this.

___________ (PATIENT INITIALS)

Opioids are controlled substances and there are numerous laws and regulations regarding the prescribing of them that your physician has to adhere to. The following requests are considered stand best practice and help our Dental Practice and you comply with these laws and regulations.

The patient agrees:

I will fill my prescription for:

- Codeine
- Hydrocodone
- Oxycodone
- Tramadol
- _________________

I will fill my prescription(s) only at one pharmacy located at _____________________________
All other prescriptions for pain medications will be revealed to Dr. ________________________
To reliably attend appointments with Dr. ______________________
To not use any illegal substances, such as cocaine, marijuana, etc. while taking opioids.
To that if a specific quantity of medication is prescribed to the last until the next scheduled appointment,
I will not request earlier prescription refills without the knowledge and consent of Dr. _______________
To safely store the medication (This is REALLY important as most of the prescription opioids now on the street were stolen from a regular use – use a locked box and do not keep them where other might see or have access to them).
That travelling with Opioid painkillers may pose problems. Before travel. Contact the appropriate travel airport (usually the consulate website of the country you are going to) and obtain a note from Dr. ________________________if necessary.
That lost/stolen/spilt Opioid medications will not be replaced.

Signature Lines

____ ______________________
Dentist signature Date

____ ______________________
Patient signature Date

____
Patient name (print)

Behavioral Health Services Providers by County

Behavioral health services, including all mental health, drug, and alcohol services, are coordinated through and provided by the following:

County	Provider	Phone
Bucks	Magellan Behavioral Health	**1-877-769-9784**
Chester	Community Care Behavioral Health	**1-866-622-4228**
Delaware	Magellan Behavioral Health	**1-888-207-2911**
Montgomery	Magellan Behavioral Health	**1-877-769-9782**
Philadelphia	Community Care Behavioral Health	**1-888-545-2600**

Members/Participants may self-refer for behavioral health services. However, primary care practitioners (PCPs) and other physical health care providers often need to recommend that a member/Participant access behavioral health services. The health care provider or their staff can obtain assistance for members/Participants needing behavioral health services by calling the toll-free numbers above.

Update: Formulary Changes
Opioid Prescription Morphine Milligram Equivalent (MME)

Effective **July 01, 2019,** Keystone First and Keystone First Community HealthChoices will be lowering the maximum morphine milligram equivalent (MME) from 90MME per day to 50MME per day.

This updated MME limit will apply along with other opioid limits that are already in place.
Prior authorization will be required for:

- All extended-release and long acting (ER/LA) opioids.
- Any opioid regimen greater than or equal to **50MME per day** (calculated across all products if members or Participants are receiving more than one opioid concurrently).
- Greater than a three-day supply of opioids for members or Participants under 21 years of age.
- Greater than a five-day supply of opioids for members or Participants 21 years of age or older.

Members or Participants that are currently undergoing treatment for cancer, in hospice, receiving palliative care or identified as having sickle cell disease will be exempt from these requirements. Claims for these members or Participants that do not auto-approve can receive a one year approval by calling the numbers shown below.

Prior authorization forms for opioid containing products, as well as opioid treatment resources may be on found on the plans websites:
www.keystonefirstpa.com → Providers → Pharmacy Services
www.keystonefirstchc.com → Providers → Pharmacy Services

If you have any questions regarding this notice, please contact Pharmacy Services:

Plan Name	Opioid Phone Number	Opioid Fax Number
Keystone First	**1-800-558-1655**	**1-978-313-8230**
Keystone First Community HealthChoices	**1-866-907-7088**	**1-855-851-4058**

Fraud, Waste, and Abuse Tip Hotline: 1-866-833-9718, 24 hours a day, seven days a week. Secure and confidential. You may remain anonymous.

May 28, 2019

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