

Opioid Products Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information <small>(required)</small>
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Pain associated with active cancer treatment or cancer not in remission</p> <p><input type="checkbox"/> Severe, persistent chronic non-cancer pain - Document the diagnosis associated with the pain: _____</p> <p><input type="checkbox"/> Sickle cell anemia</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>Clinical information:</p> <p>Is the requested medication being used to treat the patient's stage four, advanced metastatic cancer or a severe adverse health condition experienced as a result of stage four, advanced metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient filled buprenorphine/naloxone (Bunavail/Suboxone/Zubsolv) or buprenorphine (Subutex) within the past two months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes to the above, is there documentation of a treatment plan showing discontinuation of buprenorphine containing Medication Assistant Treatments (MAT)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>**Please note: Medical records (e.g., chart notes) of the above is required to be submitted along with this fax.</i></p> <p>Is there documentation of a current patient-prescriber opioid treatment agreement (signed within 1 year of request)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Was the requested medication regimen prescribed by or in consultation with a pain management specialist within last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, provide the name of the physician and date of last visit. Name: _____ Date: _____</p> <p>Select if the pain management specialist is board certified by one of the following below:</p> <p><input type="checkbox"/> American Board of Anesthesiology - Pain Management</p> <p><input type="checkbox"/> American Board of Psychiatry & Neurology - Pain Management</p> <p><input type="checkbox"/> American Board of Physical Medicine & Rehabilitation</p> <p><input type="checkbox"/> American Osteopathic Association - Pain Management</p> <p>Select if the prescriber has evaluated the patient for the following therapies below:</p> <p><input type="checkbox"/> Physical therapy</p> <p><input type="checkbox"/> Psychotherapy</p> <p><input type="checkbox"/> Adjuvant medications specific to causative condition including but not limited to any of the following: Antidepressants, anticonvulsants, muscle relaxants, anti-inflammatory agents</p>

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Reauthorization

If this is a reauthorization request, answer the following:

Does the patient have pain associated with active cancer treatment, cancer not in remission, or sickle cell anemia? Yes No

Does the patient have severe, persistent chronic non-cancer pain? Yes No

If **yes**, document the diagnosis associated with the pain: _____

Is there documentation of a current patient-prescriber opioid treatment agreement (signed within 1 year of request)? Yes No

Is there documentation that a urine drug screen (UDS) will be performed by the prescriber within 1 year of request? Yes No

Medication history:

For Apadaz or Benzhydrocodone-acetaminophen, answer the following:

Has the patient had an inadequate response to or inability to tolerate generic hydrocodone-acetaminophen AND generic oxycodone-acetaminophen? Yes No

For Hysingla ER, answer the following:

Has the patient had an inadequate response to or inability to tolerate Xtampza ER? Yes No

Please list all generic opioid(s) the patient has had an inadequate response to or an inability to tolerate:

Quantity Limit and Day Supply Limit Requests:

What is the quantity requested per DAY? _____

Does the patient's diagnosis include acute pain? Yes No

Has the prescriber reviewed the patient's history in state Prescription Drug Monitoring Program website? Yes No

Has the prescriber counseled the patient (or the patient's representative) on risk of addiction? Yes No

Is the substance abuse screening done by the prescriber? Yes No

Is there documentation of a current patient-prescriber opioid treatment agreement (signed within 1 year of request)? Yes No

Does the requested dose and frequency exceed FDA approved dosing? Yes No

Is the requested dose and frequency supported by compendia? Yes No

Is there documentation indicating medical necessity for a quantity that exceeds the plan limit (e.g., GI malabsorption) or the dose cannot be achieved with commercially available clinical dosage forms? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.