

Please complete ALL information below and fax your request to 1-888-671-5285

Short-acting Opioids for Continuation beyond 30 days Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
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 (required)

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 (required)

Select the diagnosis below:

- Pain associated with active cancer treatment or cancer not in remission
 Severe, persistent chronic non-cancer pain
 - Document the diagnosis associated with the pain: _____
 Sickle cell anemia
 Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

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

Was the requested medication regimen prescribed by or in consultation with a pain management specialist within the last 6 months? Yes No

If **yes**, provide the name of the physician and date of last visit. Name: _____ Date: _____

Select if the pain management specialist is board certified by one of the following below:

- American Board of Anesthesiology - Pain Management
 American Board of Psychiatry & Neurology - Pain Management
 American Board of Physical Medicine & Rehabilitation
 American Osteopathic Association - Pain Management

Select if the prescriber has evaluated the patient for the following therapies below:

- Physical therapy Adjuvant medications specific to causative condition including but not limited to any of the following:
 Psychotherapy Antidepressants, anticonvulsants, muscle relaxants, anti-inflammatory agents

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

Quantity Limit Requests:

What is the quantity requested per DAY? _____

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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of the Pharmacy Benefit Manager. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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