**Prior authorization is approved for a maximum of 6 months only**

- New Prescription
- Refill (Patient has been taking this medication)

Please check the appropriate box for the Opioid Prior Authorization request.

- >90 MME Limit

Use a separate form for EACH medication request:

- Medication: ____________________________ Strength: _________ Quantity: ________
- SIG: ____________________________ Length of Treatment ________ months.

Clinical Considerations:

- Y  N  Is the Patient Pregnant?

Y  N

- Patient receiving opioid due to cancer treatment. Cancer type:
- Patient receiving opioid due to sickle cell disease.
- Patient is in hospice care.
- Patient is receiving palliative care (ICD-10 diagnosis code of Z51.5)
- Patient is in a LTC (Long Term Care) facility.

Attestation required for all of the following in order to receive a PA.

Y  N

- Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
- Patient has/will have random Urine Drug Screens.
- Naloxone prescription was provided or offered to patient/patient’s household.
- Patient-Prescriber Pain Management/Opioid Treatment Agreement/Contract signed and in Medical record?

I certify that the benefits of Opioid treatment for this patient outweigh the risks of treatment. Prescriber’s Signature__________________________________________ Date_____________________

Fax completed form to 877-328-9799.