



PRIOR AUTHORIZATION REQUEST

Long Acting Opioids

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for ALL PA requests.

- | | | | |
|---|---|-----|----|
| 1 | Is the request an INITIAL or CONTINUATION of therapy? | | |
| | <input type="checkbox"/> Initial (If checked, go to 2) | | |
| | <input type="checkbox"/> Continuation (If checked, go to 5) | | |
| 2 | Is the request for one of the following formulary options: A) Fentanyl patch, B) Morphine sulfate ER, C) Oxycodone ER?
[If yes, skip to question 6.] | Yes | No |
| 3 | Has the patient tried ALL of the following alternatives for at least 3 months in the last 365 days: A) Fentanyl patch, B) Morphine sulfate ER, C) Oxycodone ER? | Yes | No |

If you have any
questions, call:
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[If yes, skip to question 6.]

- | | | | |
|----|---|-----|----|
| 4 | <p>Is the patient intolerant to or contraindicated to ALL of the following preferred alternatives: A) Fentanyl patch, B) Morphine sulfate ER, C) Oxycodone ER?
 ACTION REQUIRED: Submit supporting documentation.
 [NOTE: Must have clinical documentation of intolerance to or contraindication to ALL preferred alternatives: Fentanyl patch, Morphine Sulfate ER, and Oxycodone ER.]
 [If yes, skip to question 6.]
 [If no, no further questions.]</p> | Yes | No |
| 5 | <p>Is the patient responding to treatment?
 [If no, no further questions.]</p> | Yes | No |
| 6 | <p>Is the patient currently an inpatient at an acute care hospital?</p> | Yes | No |
| 7 | <p>Is the patient being discharged from the hospital or emergency department?</p> | Yes | No |
| 8 | <p>Is the patient pregnant?</p> | Yes | No |
| 9 | <p>Is the patient undergoing active cancer treatment? If yes, please document the type of cancer _____.
 [If yes, no further questions.]</p> | Yes | No |
| 10 | <p>Does the patient have sickle cell disease?
 [If yes, no further questions.]</p> | Yes | No |
| 11 | <p>Is the patient being treated as part of hospice care, long term care, skilled nursing facility care, or palliative care (diagnosis code Z51.5)? If yes, please document the diagnosis _____.
 [If yes, no further questions.]</p> | Yes | No |
| 12 | <p>Are you an inpatient hospital, ambulatory surgery center, or emergency room prescriber, OR are you an outpatient prescriber providing ongoing care?</p> <p><input type="checkbox"/> Inpatient hospital, ambulatory surgery, or emergency room prescriber (If checked, go to 13)</p> <p><input type="checkbox"/> Outpatient prescriber providing ongoing care (If checked, go to 17)</p> <p><input type="checkbox"/> None of the above. Please document prescriber's specialty and setting _____ (If checked, go to 17)</p> | | |
| 13 | <p>Have you discussed the risks/benefits associated with opioid use with patient or the patient's household?</p> | Yes | No |
| 14 | <p>Is the patient exempt from need for a Patient-Prescriber Pain Management/Opioid Treatment Agreement and random urine drug screen (UDS) because he/she is</p> | Yes | No |

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being discharged from the Hospital/Ambulatory surgery center (ASC)/Emergency room (ER) and opioid treatment prescribed by the discharging provider will be for less than 30 days or the need for further opioid use will be re-evaluated by an outpatient provider within 30 days?

- | | | | |
|----|--|-----|----|
| 15 | Has a Naloxone prescription been provided or offered to the patient or the patient's household? | Yes | No |
| 16 | Have you reviewed the Controlled Substance Prescriptions in Prescription Drug Monitoring Program (PDMP) (Chesapeake Regional Information System for our Patients [CRISP])?
[If yes, skip to question 22.]
[If no, no further questions.] | Yes | No |
| 17 | Will the patient have random Urine Drug Screens? | Yes | No |
| 18 | Is the Patient/Prescriber Pain Management/Opioid Treatment Agreement signed and in medical record? | Yes | No |
| 19 | Have you discussed the risks/benefits associated with opioid use with patient or the patient's household? | Yes | No |
| 20 | Has a Naloxone prescription been provided or offered to the patient or the patient's household? | Yes | No |
| 21 | Have you reviewed the Controlled Substance Prescriptions in Prescription Drug Monitoring Program (PDMP) (Chesapeake Regional Information System for our Patients [CRISP])?
[If no, no further questions.] | Yes | No |
| 22 | Has the patient's diagnosis been submitted? Please document the diagnosis _____.
[If no, no further questions.] | Yes | No |
| 23 | Does the requested quantity exceed the quantity limits placed on this medication? Please document the requested quantity for the medication _____.
[If no, no further questions.] | Yes | No |
| 24 | Has the provider evaluated the need for the requested quantity and assessed opportunities to wean opioid utilization when appropriate? ACTION REQUIRED: Submit supporting documentation. | Yes | No |

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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