



PRIOR AUTHORIZATION REQUEST

Opioids (Long and Short Acting)

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is the request an INITIAL or CONTINUATION of therapy?

☐ Initial (If checked, go to 2)

☐ Continuation (If checked, go to 5)

2 Is the request for one of the preferred opioid products?

Yes No

[Note: Preferred short-acting agents include Morphine IR tabs, Oxycodone IR tabs, Hydromorphone IR tabs, Tramadol IR tabs, Hydrocodone/APAP tabs,

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Oxycodone/APAP tabs, Hydrocodone/IBU tabs, APAP/Codeine tabs, Tramadol/APAP tabs.

Preferred long-acting agents Fentanyl patch, Morphine ER tabs, Oxymorphone ER tabs, Tramadol ER tabs.]

[If yes, skip to question 6.]

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|----|--|-----|----|
| 3 | <p>Has the patient tried at least THREE of the preferred formulary alternatives for at least 3 months in the last 365 days?
[If yes, skip to question 6.]</p> | Yes | No |
| 4 | <p>Is the patient intolerant to or contraindicated to at least THREE preferred alternatives? ACTION REQUIRED: Submit supporting documentation.
[Note: Must have clinical documentation of intolerance to or contraindication to at least THREE preferred alternatives.]
[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?
[Go to question 7.]</p> | Yes | No |
| 7 | <p>Is the patient being discharged from the hospital or emergency department?
[Go to question 8.]</p> | Yes | No |
| 8 | <p>Is the patient pregnant?
[Go to question 9.]</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>☐ Inpatient hospital, ambulatory surgery, or emergency room prescriber (If checked, go to 13)</p> <p>☐ Outpatient prescriber providing ongoing care (If checked, go to 17)</p> | | |

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☐ None of the above. Please document prescriber's specialty and setting

(If checked, go to 17)

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|----|---|-----|----|
| 13 | Have you discussed the risks/benefits associated with opioid use with patient or the patient's household?
[Go to question 14.] | Yes | No |
| 14 | 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 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?
[Go to question 15.] | Yes | No |
| 15 | Has a Naloxone prescription been provided or offered to the patient or the patient's household?
[Go to question 16.] | 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? ACTION REQUIRED: Submit supporting documentation.
[Note: Documentation with urine drug screen (UDS) results required.]
[If no, no further questions..] | Yes | No |
| 18 | Is the Patient/Prescriber Pain Management/Opioid Treatment Agreement signed and in medical record?
[Go to question 19.] | Yes | No |
| 19 | Have you discussed the risks/benefits associated with opioid use with patient or the patient's household?
[Go to question 20.] | Yes | No |
| 20 | Has a Naloxone prescription been provided or offered to the patient or the patient's household?
[Go to question 21.] | 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 |

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|----|--|-----|----|
| 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:

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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