

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 <b>generic substitution</b> is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

### 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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