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

Opioid Products Prior Authorization Request Form (Page 1 of 2)

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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:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ 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 the requested medication being used to treat the patient's stage four, advanced metastatic cancer or a severe adverse health condition experienced as a result of stage four, advanced metastatic cancer? ❑ **Yes** ❑ **No**

Has the patient filled buprenorphine/naloxone (Bunavail/Suboxone/Zubsolv) or buprenorphine (Subutex) within the past two months? ❑ **Yes** ❑ **No**

If **yes** to the above, is there documentation of a treatment plan showing discontinuation of buprenorphine containing Medication Assistant Treatments (MAT)? ❑ **Yes** ❑ **No**

***Please note: Medical records (e.g., chart notes) of the above is required to be submitted along with this fax.*

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

Opioid Products Prior Authorization Request Form (Page 2 of 2)

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Reauthorization

If this is a reauthorization request, answer the following:

Does the patient have pain associated with active cancer treatment, cancer not in remission, or sickle cell anemia? ❑ **Yes** ❑ **No**

Does the patient have severe, persistent chronic non-cancer pain? ❑ **Yes** ❑ **No**

If **yes**, document the diagnosis associated with the pain: _____

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

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

Medication history:

For Apadaz or Benzhydrocodone-acetaminophen, answer the following:

Has the patient had an inadequate response to or inability to tolerate generic hydrocodone-acetaminophen AND generic oxycodone-acetaminophen? ❑ **Yes** ❑ **No**

For Hysingla ER, answer the following:

Has the patient had an inadequate response to or inability to tolerate Xtampza ER? ❑ **Yes** ❑ **No**

Please list all generic opioid(s) the patient has had an inadequate response to or an inability to tolerate:

_____

Quantity Limit and Day Supply Limit Requests:

What is the quantity requested per DAY? _____

Does the patient's diagnosis include acute pain? ❑ **Yes** ❑ **No**

Has the prescriber reviewed the patient's history in state Prescription Drug Monitoring Program website? ❑ **Yes** ❑ **No**

Has the prescriber counseled the patient (or the patient's representative) on risk of addiction? ❑ **Yes** ❑ **No**

Is the substance abuse screening done by the prescriber? ❑ **Yes** ❑ **No**

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

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.