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

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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 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
❑ Psychotherapy
❑ Adjuvant medications specific to causative condition including but not limited to any of the following: 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.