BlueCross BlueShield of Alabama

# OPIOIDS PRIOR AUTHORIZATION FORM

ONLY the prescriber may complete this form.

| Patient Information | | | | Today's Date |
|---|---|---|---|---|
| Patient First Name: | Patient Last Name: | | MI. | DOB (mm/dd/yyyy): |
| Patient Street Address: | City: | State: | Zip: | Patient Phone: |

| Insurance Information | |
|---|---|
| Member ID Number: | Group Number: |

| Prescriber/Clinic Information | | | |
|---|---|---|---|
| Prescriber First Name: | Prescriber Last Name: | NPI: | Specialty: |
| Clinic Name: | Contact Name: | Phone: | Secure Fax: |

| Medical information. Please attach additional information as needed. | |
|---|---|
| Patient Diagnosis with ICD-9 Code: | ICD-10 Code: |
| Medication and Strength Requested: | |
| Dosing Schedule: | Quantity per Month: |

**ALL REQUESTS**

Please list the medications the patient has previously tried and failed for the treatment of this diagnosis:

| | Date: | | Date: |
|---|---|---|---|
| | Date: | | Date: |
| | Date: | | Date: |

| | |
|---|---|
| Please list all reasons for selecting the requested **medication, dosing schedule and quantity** over alternatives (e.g.contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried.) | |
| Please list all other medications the patient will take in **combination** with the requested medication. | |

| | | |
|---|---|---|
| Is the patient currently treated with the requested medication? | ☐ **YES**<br>☐ **NO** | **If yes:** When was treatment with the requested medication started? |

# OPIOIDS PRIOR AUTHORIZATION FORM

| Patient First Name: | Patient Last Name: | MI: | DOB: (mm/dd/yyyy) |
|---|---|---|---|
| | | | |

**For Opioid Extended Release (ER) Requests**

| | |
|---|---|
| **The patient's medication history includes a trial of at least 7 days of an immediate-acting opioid.** | ☐ YES ☐ NO |
| **Is the patient eligible for hospice care*?**<br>**Please provide medical record documentation.* | ☐ YES ☐ NO |
| **Does the patient have a diagnosis of chronic cancer pain due to an active malignancy?**<br>**Please provide medical record documentation.* | ☐ YES ☐ NO |
| **Is treatment for chronic non-cancer pain?**<br>**If yes: The following documentation must be provided for review:**<br>**1)** Formal Consultative Evaluation including:<br>• Diagnosis<br>• A complete medical history which includes previous and current pharmacological and non-pharmacological therapy | ☐ YES ☐ NO |
| **The prescriber has confirmed that a patient-specific pain management plan is on file for the patient.** | ☐ YES ☐ NO |
| **Has the prescriber confirmed that the patient is not diverting the requested medication, according to the state's prescription drug monitoring program (PDMP) if applicable?** | ☐ YES ☐ NO |

**For Opioid Immediate Release (IR) Requests**

| | |
|---|---|
| **Is the patient opioid naive?** (Note: Naive is defined as 7 days or greater without being on an opioid and not taking an opioid every day in the previous 60 days. Patients that received opioids in a hospital are considered opioid naive.) | ☐ YES ☐ NO |
| **Is the patient eligible for hospice care*?**<br>**Please provide medical record documentation.* | ☐ YES ☐ NO |
| **Does the patient have a diagnosis of chronic cancer pain due to an active malignancy?**<br>**Please provide medical record documentation.* | ☐ YES ☐ NO |
| **Is treatment for chronic non-cancer pain?**<br>**If yes: The following documentation must be provided for review:**<br>**1)** Formal Consultative Evaluation including:<br>• Diagnosis<br>• A complete medical history which includes previous and current pharmacological and non-pharmacological therapy | ☐ YES ☐ NO |
| **The prescriber has confirmed that a patient-specific pain management plan is on file for the patient.** | ☐ YES ☐ NO |
| **Has the prescriber confirmed that the patient is not diverting the requested medication, according to the state's prescription drug monitoring program (PDMP) if applicable?** | ☐ YES ☐ NO |

**Physician's Signature:**

Date Signed ______________________

**Please fax or mail fax the signed and completed form to:**


Pharmacy Review
Post Office Box 3210
Auburn, AL 36831

**TOLL FREE - Fax: 1-866-606-6021**

BlueCross BlueShield of Alabama


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