OPIOIDS (EXTENDED RELEASE)
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

WYOMING
An independent licensee of the Blue Cross and Blue Shield Association

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For Preferred Drug List information, please visit www.myprime.com or the Blue Cross and Blue Shield of Wyoming web site at www.bcbswy.com.

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:

- ☐ Chronic cancer pain due to active malignancy
- ☐ Chronic non-cancer pain
- ☐ Post-operative pain management following tonsillectomy and/or adenoidectomy
- ☐ Other (ICD code plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent?..... ☐ Yes ☐ No
2. Has the patient been treated with the requested agent in the past 90 days?..... ☐ Yes ☐ No
   If yes, is the patient at risk if therapy with the requested agent is changed?..... ☐ Yes ☐ No
   If yes, please explain: _____
3. Is the patient eligible for hospice care?..... ☐ Yes ☐ No
4. Is the patient concurrently taking a buprenorphine or buprenorphine/naloxone agent for opioid dependence treatment?..... ☐ Yes ☐ No
   If yes, please provide supporting explanation: _____
5. Does the patient have any FDA labeled contraindications to the requested agent? ..... ☐ Yes ☐ No
6. Please list all reasons for selecting the requested medication, strength, dosing schedule and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____
7. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products.)

_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For chronic non-cancer pain:

8. Is the patient undergoing treatment for chronic non-cancer pain? ☐ Yes ☐ No

   If yes, has the patient had a formal, consultative evaluation which includes ALL of the following: 1) diagnosis, 2) complete medical history which includes previous and current pharmacological and non-pharmacological therapy, and 3) the need for continued opioid therapy has been assessed? ☐ Yes ☐ No

9. Is the requested agent being prescribed as an as-needed (PRN) analgesic? ☐ Yes ☐ No

10. Does the patient's medication history include at least a 7 days trial of an immediate-acting opioid? ☐ Yes ☐ No

    If no, does the patient have an intolerance or hypersensitivity to immediate-acting opioids that is not expected to occur with the requested agent? ☐ Yes ☐ No

    If yes, please explain: _____

    _____

    If no, does the patient have an FDA labeled contraindication to ALL immediate-acting opioids that is not expected to occur with the requested agent? ☐ Yes ☐ No

    If yes, please explain: _____

    _____

11. Is there a patient-specific pain management plan is on file for the patient? ☐ Yes ☐ No

12. Is the patient diverting the requested medication, according to the patient's records in the state's prescription drug monitoring program (PDMP), if applicable? ☐ Yes ☐ No

Please fax or mail this form to:
Blue Cross Blue Shield of Wyoming
Medical Review Department
PO Box 2266
Cheyenne, Wyoming 82003-2266

TOLL FREE
Fax: 307.634.5742 Phone: 800.442.2376

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