BlueCross BlueShield Federal Employee Program.

OPIOID DRUGS
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

*****The CDC's Opioid Guideline Mobile App is designed to help providers with Morphine Milligram Equivalent (MME) calculations when prescribing opioids. The CDC app is available for free download on Google Play for Android devices and in the Apple Store for iOS devices*****

NOTE: Form must be completed in its **entirety** for processing

Select Drug:	**Brand/Generic:**	**Drug Strength:**	**Dosing Directions:**
EXTENDED RELEASE (ER) OPIOIDS			
❑**Buprenorphine film**	❑Brand ❑Generic		
❑**Buprenorphine patch**	❑Brand ❑Generic		
❑**Fentanyl patch**	❑Brand ❑Generic		
❑**Hydrocodone**	❑Brand ❑Generic		
❑**Hydromorphone**	❑Brand ❑Generic		
❑**Morphine sulfate**	❑Brand ❑Generic		
❑**Morphine sulfate/naltrexone**	❑Brand ❑Generic		
❑**Oxycodone**	❑Brand ❑Generic		
❑**Oxymorphone**	❑Brand ❑Generic		
❑**Tapentadol**	❑Brand ❑Generic		
❑**Tramadol**	❑Brand ❑Generic		
IMMEDIATE RELEASE (IR) OPIOIDS			
❑**Butorphanol nasal spray**	❑Brand ❑Generic		
❑**Codeine tablet**	❑Brand ❑Generic		
❑**Hydromorphone liquid**	❑Brand ❑Generic		
❑**Hydromorphone suppository**	❑Brand ❑Generic		
❑**Hydromorphone tablet**	❑Brand ❑Generic		
❑**Levorphanol tablet**	❑Brand ❑Generic		
❑**Meperidine oral solution**	❑Brand ❑Generic		
❑**Meperidine tablet**	❑Brand ❑Generic		
❑**Morphine sulfate oral solution**	❑Brand ❑Generic		
❑**Morphine sulfate suppository**	❑Brand ❑Generic		
❑**Morphine sulfate tablet**	❑Brand ❑Generic		
❑**Oxycodone capsule**	❑Brand ❑Generic		
❑**Oxycodone oral solution**	❑Brand ❑Generic		
❑**Oxycodone tablet**	❑Brand ❑Generic		
❑**Oxymorphone tablet**	❑Brand ❑Generic		
❑**Pentazocine/naloxone tablet**	❑Brand ❑Generic		
❑**Tapentadol tablet**	❑Brand ❑Generic		
❑**Tramadol oral solution**	❑Brand ❑Generic		
❑**Tramadol tablet**	❑Brand ❑Generic		

PLEASE PROCEED TO PAGE 2 FOR ADDITONAL DRUGS AND QUESTIONS

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

Select Drug:	Brand/Generic:	Drug Strength:	Dosing Directions:
IMMEDIATE RELEASE (IR) OPIOID COMBO			
❑**Benzhydrocodone/APAP**	❑Brand ❑Generic		
❑**Celecoxib/tramadol tablet**	❑Brand ❑Generic		
❑**Codeine/APAP solution**	❑Brand ❑Generic		
❑**Codeine/APAP tablet**	❑Brand ❑Generic		
❑**Dihydrocodeine/APAP/caffeine tablet**	❑Brand ❑Generic		
❑**Hydrocodone/APAP elixir**	❑Brand ❑Generic		
❑**Hydrocodone/APAP solution**	❑Brand ❑Generic		
❑**Hydrocodone/APAP tablet**	❑Brand ❑Generic		
❑**Hydrocodone/ibuprofen tablet**	❑Brand ❑Generic		
❑**Oxycodone/APAP solution**	❑Brand ❑Generic		
❑**Oxycodone/APAP tablet**	❑Brand ❑Generic		
❑**Oxycodone/ASA tablet**	❑Brand ❑Generic		
❑**Oxycodone/ibuprofen tablet**	❑Brand ❑Generic		
❑**Tramadol/APAP tablet**	❑Brand ❑Generic		
OPIOID POWDERS			
❑**Butorphanol Powder**	❑Brand ❑Generic		
❑**Codeine Powder**	❑Brand ❑Generic		
❑**Hydrocodone Powder**	❑Brand ❑Generic		
❑**Hydromorphone Powder**	❑Brand ❑Generic		
❑**Levorphanol Powder**	❑Brand ❑Generic		
❑**Meperidine Powder**	❑Brand ❑Generic		
❑**Morphine Powder**	❑Brand ❑Generic		
❑**Oxycodone Powder**	❑Brand ❑Generic		
❑**Oxymorphone Powder**	❑Brand ❑Generic		

*****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

******Non-covered branded medications must go through prior authorization and the formulary exception process**

1. What is the total MME per day of **ALL** opioids added together for the patient's current pain regimen? ***Please select answer below:***

   ❑**90 MME per day or less** ***(specify all opioids)***: _____

   ❑**Greater than 90 MME per day** ***(specify all opioids)***: _____

2. Is this medication being used to treat any of the following: pain associated with cancer or prescribed by a board-certified oncologist, pain associated with sickle cell disease, **OR** treatment associated with hospice, palliative, or end-of-life care? ❑Yes***** ❑No

   ****If YES***, please specify which: ❑Pain associated with cancer or prescribed by a board-certified oncologist
   ❑Pain associated with sickle cell disease
   ❑Treatment associated with hospice, palliative, or end-of-life care

3. Will the patient be using this medication concurrently with Lucemyra, methadone (Dolophine), or a buprenorphine medication such as Suboxone for opioid addiction? ❑Yes***** ***(*If YES, please select medication below)*** ❑No

   ❑Buprenorphine medication for opioid addiction ❑Lucemyra ❑Methadone (Dolophine)

4. Will the patient also be taking Fioricet with codeine (butalbital/APAP/caffeine/codeine) or Fiorinal with codeine (butalbital/aspirin/caffeine/codeine)? ❑Yes***** ***(*If YES, please specify which medication below)*** ❑No

   ❑Fioricet with codeine (butalbital/APAP/caffeine/codeine) **OR** ❑Fiorinal with codeine (butalbital/aspirin/caffeine/codeine)

5. Is the patient being treated for pain? ❑Yes ❑No

6. Does the prescriber agree to assess the patient for signs and symptoms of serotonin syndrome? ❑Yes ❑No

PLEASE PROCEED TO PAGE 3 FOR ADDITONAL QUESTIONS

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PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

7. Does the prescriber agree to participate in the ***Opioid Analgesic REMS program **AND** to monitor for abuse, misuse, addiction, and overdose and discontinue if necessary? ❑Yes ❑No

   ***Opioid Analgesic REMS Program*: https://opioidanalgesicrems.com**

8. Does the prescriber agree to evaluate the patient's response to therapy before changing dose or adding additional opioid medications? ❑Yes ❑No

9. Will the patient be using this medication in combination with alprazolam (Xanax), clonazepam (Klonopin), diazepam (Valium), or lorazepam (Ativan)? ❑Yes ❑No

10. Will the patient be using this medication in combination with oxazepam (Serax), chlordiazepoxide (Librium), or clorazepate dipotassium (Tranxene)? ❑Yes ❑No

11. Has the patient received opioid therapy within the past 180 days? ***Please select answer below:***

    ❑**Yes**: Does the prescriber agree to continue to assess the patient for the benefits of pain control, for example, by implementing a care plan, monitoring for signs of misuse/abuse using standard lab screening (i.e., urine, blood) and evaluating severity of pain after three months of therapy? ❑Yes ❑No

    ❑**No**: Please answer the following questions:

    a. Have alternative treatments, including non-opioid analgesics and opioid immediate-release analgesics, been ineffective, not tolerated, or inadequate at controlling the patient's pain? ❑Yes ❑No

    b. Does the prescriber agree to assess the patient for the benefits of pain control, for example, by implementing a care plan, monitoring for signs of misuse/abuse using standard lab screening (i.e., urine, blood) and evaluating severity of pain after three months of therapy? ❑Yes ❑No

    c. **Age 18 or Older:** In the past 180 days, has the patient been on an immediate release or extended release opioid **OR** have filled an initial 7-day supply of **ANY** immediate release opioid (this may include the requested medication)? ❑Yes ❑No

12. **Age 17 or younger**: In the last 180 days, has the patient filled at least a 3-day supply of **ANY** opioid (this may include the requested medication)? ❑Yes ❑No

13. **Age 18 or Older:** Has the patient filled at least a 10-day supply or more of **ANY** immediate release (IR) opioid in the last 180 days **OR** is switching from another long-acting (ER) opioid? ❑Yes ❑No

14. **Duragesic (Fentanyl) Patch Request**: Please answer the following questions:

    a. Is the requested dosing regimen every 48 hours, with a total Duragesic dose less than or equal to 62.5 mcg? ❑Yes* ❑No

    If YES, has the patient experienced failure, side effects, or inadequate pain control at a higher (mg) patch every 72 hours than the one being requested now? ❑Yes ❑No

    b. Is the patient using multiple strengths? ❑Yes ❑No

    c. How often is the patient changing this patch? ***Please select answer below:***

    ❑Daily (every 24 hours/QD) ❑Every other day (every 48 hours/QOD) ❑Every 3 days (every 72 hours/Q 72 H)

    ❑Other ***(please specify frequency)***: _____

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***