OPIOIDS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.
By submitting this form, you attest that all information provided is true and accurate.

PLEASE NOTE: Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit www.myprime.com

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

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):
Patient Street Address:	City, State:	ZIP:	Patient Phone:
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

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 range:_____ _____ Date range:_____
_____ Date range:_____ _____ Date range:_____
_____ Date range:_____ _____ Date range:_____

Is the patient currently treated with the requested agent? ..... ☐ Yes ☐ No

Does the requested medication contain tramadol, dihydrocodeine, or codeine? ..... ☐ Yes ☐ No

If yes: Is the requested medication being used for post-operative pain management following a tonsillectomy and/or adenoidectomy? ..... ☐ Yes ☐ No

Is the request for one of the following brand name agents: Butrans, Duragesic, Hysingla, MS Contin, or Zohydro? ..... ☐ Yes ☐ No

If yes: Does the patient have an intolerance or hypersensitivity to the generic equivalent that is not expected to occur with the requested brand agent? Please note, generic equivalents are: buprenorphine patch for Butrans, fentanyl patch for Duragesic, hydrocodone ER tabs for Hysingla, morphine sulfate ER tabs for MS Contin, and hydrocodone ER caps for Zohydro. ..... ☐ Yes ☐ No

If yes: Please explain intolerance or hypersensitivity:_____

_____

Please continue to the next page.

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

If no: Does the patient have an FDA labeled contraindication to the generic equivalent that is not expected to occur with the brand agent? ..... ☐ Yes ☐ No

If yes: Please explain contraindication: _____

_____

If no: Is there information to support the use of the requested brand agent over the generic equivalent? ... ☐ Yes ☐ No

If yes: Please explain:_____

_____

For Opioid Extended Release (ER) Requests

Will the patient also be treated with buprenorphine or buprenorphine/naloxone for opioid dependence at the same time as the requested medication?..... ☐ Yes ☐ No

Is there information in support of use of opioids with buprenorphine or buprenorphine/naloxone for opioid dependence treatment?..... ☐ Yes ☐ No

If yes: Please explain: _____

_____

Please select the patient's indication for use of the requested drug and answer any corresponding questions:

☐ **Patient is eligible for end-of-life-care (including hospice or palliative care)**

Please note, medical record documentation must be provided for review.

☐ **Treatment of sickle cell disease**

Please note, medical record documentation must be provided for review.

☐ **Treatment of chronic cancer pain due to an active malignancy**

Please note, medical record documentation must be provided for review.

Has the patient been evaluated by a board-certified oncologist in the past 12 months? Please note, medical record documentation must be provided for review..... ☐ Yes ☐ No

☐ **Treatment of chronic NON-cancer pain**

The following documentation from the medical record must be provided for review:

1) Formal Consultative Evaluation including:
   - Diagnosis
   - A complete medical history which includes previous and current pharmacological and non-pharmacological therapy

2) Patient Specific Pain Management Treatment Plan including:
   - Treatment goals
   - Anticipated duration of opioid therapy
   - Periodic (at least annually) urine drug screening results to confirm adherence to the treatment plan

Is the prescriber a specialist in or has the patient been evaluated by a specialist in the area of practice related to the source of the chronic non-cancer pain?..... ☐ Yes ☐ No

Has the prescriber reviewed the patient's records in the state's prescription drug monitoring program (PDMP) and has determined that the opioid dosages and combinations of opioids and other controlled substances withing the patient's records do NOT indicate the patient is at high risk for overdose?..... ☐ Yes ☐ No

Does the prescriber have a signed informed opioid consent/opioid agreement with the patient?..... ☐ Yes ☐ No

If yes: Please provide a copy of the agreement or medical record documentation.

Will the patient be taking the requested drug concurrently with another long-acting/extended-release narcotic analgesic agent? ..... ☐ Yes ☐ No

Does the patient have any FDA labeled contraindications to the requested agent? ..... ☐ Yes ☐ No

If yes: Please provide contraindication(s):_____

_____

Please continue to the next page.

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

For Nucynta (tapentadol) requests:

Has the patient tried and had inadequate pain relief from at least ONE generic oral long acting opioid drug? .... ☐ Yes ☐ No

Does the patient have a hypersensitivity or contraindication to ALL generic oral long acting opioid drugs? ..... ☐ Yes ☐ No

If yes: Please explain: _____

_____

Does the patient have a diagnosis of diabetic neuropathy? ..... ☐ Yes ☐ No

If yes: Has the patient tried and failed any of the following? (Check all that apply.) ..... ☐ Yes ☐ No

☐ Amitriptyline ☐ Duloxetine ☐ Gabapentin

☐ Pregabalin ☐ Morphine ER ☐ Tramadol

If currently treated with the requested medication: Did a prior health plan pay for the patient's medication durir the 90 days immediately before this request? Please note documentation of a health plan paid claim for the medication during the 90 days immediately before the request must be submitted..... ☐ Yes ☐ No

For Opioid Immediate Release (IR) Requests

Is the patient opioid naïve? (Note: Naïve is defined as 7 days or greater without being on an opioid and not taking an opioid every day in the previous 180 days. Patients that received opioids in a hospital are considered opioid naïve.) ... ☐ Yes ☐ No

Is the patient eligible for end-of-life-care (including hospice or palliative care)? ..... ☐ Yes ☐ No

Does the patient have a diagnosis of cancer? ..... ☐ Yes ☐ No

Does the patient have a diagnosis of sickle cell disease? ..... ☐ Yes ☐ No

Is treatment for chronic non-cancer pain? ..... ☐ Yes ☐ No

If yes: Is the prescriber a specialist in, or has the patient been evaluated by a specialist in, the area of practice related to the source of the chronic non-cancer pain? ..... ☐ Yes ☐ No

Has the patient had a formal, consultative evaluation including all of the following: diagnosis AND complete medical history which includes previous and current pharmacological and non-pharmacological therapy? ..... ☐ Yes ☐ No

Please indicate:

☐ Date of service (if applicable): (mm/dd/yyyy):_____

☐ Start of treatment: Start date (mm/dd/yyyy):_____

☐ Continuation of therapy: Date of last treatment (mm/dd/yyyy): _____

What is the priority level of this request?

☐ Standard

☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

If yes: Please specify: _____

_____

Please fax or mail this form to:
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Eagan, MN 55121

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183