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 medication? ☐ Yes ☐ No

Does the requested medication contain tramadol 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

For Opioid Extended Release (ER) Requests

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

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

If yes: Please provide documentation to support concurrent use.

Is the patient eligible for hospice care? ☐ Yes ☐ No

If yes: Please provide medical record documentation.

Does the patient have a diagnosis of chronic cancer pain due to an active malignancy? **Please note: medical record documentation must be provided for review.** ☐ Yes ☐ No

If yes: 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

Please continue to the next page.

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

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

If yes: The following documentation 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
   - Urine drug screening results (at least annually) to confirm adherence to the treatment plan

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

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.

For Nucynta (tapentadol) requests:

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

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 during 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 enrolled in a hospice program or does the patient meet hospice criteria for life expectancy of six months or less? ..... ☐ Yes ☐ No

Does the patient have a diagnosis of cancer? ..... ☐ 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

If yes: The following documentation must be provided for review:

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

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:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183