OPIOIDS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

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 formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review

☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from 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 ☐ Sickle cell anemia

☐ Other (ICD code plus description) _____

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

For all requests:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
   If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.** ☐ Yes ☐ No
2. Is the requested agent being prescribed for palliative care or compassionate use (e.g., where the benefits of pain relief and patient comfort outweigh the risk of potential opioid related overdose/death)? ☐ Yes ☐ No
   If yes, please explain: _____
3. Is the patient enrolled in hospice care or meets hospice criteria for life expectancy of six months or less? ☐ Yes ☐ No
4. Is the patient currently being treated with the requested dose/quantity in the last 90 days? ☐ Yes ☐ No
5. Is the dose requested appropriate based on recommended dosage titrations in FDA labeling or Compendia (i.e., dosage increase is not excessive; patient has been on current dose a sufficient length of time to determine efficacy/adverse effects)? ☐ Yes ☐ No
   If yes, please explain: _____
6. Can the prescribed dose be achieved using a lesser quantity of a higher strength? ☐ Yes ☐ No
   If no, please explain: _____
7. Please list all reasons for selecting the requested agent, 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). _____

Please continue to the next page.

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

8. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? ☐ Yes ☐ No
9. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.** ☐ Yes ☐ No
10. If yes to either of the previous questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? ☐ Yes ☐ No

Please submit chart notes to support the answers to the following questions:

11. Has the patient tried and had an inadequate response to Xtampza? ☐ Yes ☐ No
12. Was Xtampza discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
13. Does the patient have an intolerance, or hypersensitivity to Xtampza? ☐ Yes ☐ No
14. Does the patient have an FDA labeled contraindication to Xtampza? ☐ Yes ☐ No
15. Is Xtampza expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No
16. Is Xtampza is not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
17. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Xtampza and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
18. Is the patient undergoing treatment of chronic non-cancer pain? ☐ Yes ☐ No

If yes, please answer the following:

- Has a formal, consultative evaluation been conducted which includes all of the following: diagnosis, a complete medical history which includes previous and current pharmacological and non-pharmacological therapy, and the need for continued opioid therapy has been assessed? **Please note, chart notes are required.** ☐ Yes ☐ No
- Is the patient routinely (at least every 3 months) being assessed for function, pain status, and opioid dose? ☐ Yes ☐ No
- Has the prescriber confirmed that the patient is not diverting controlled substances, according to the patient's records in the state's prescription drug monitoring program (PDMP), if applicable? ☐ NA ☐ Yes ☐ No
- Is the patient concurrently using a benzodiazepine? ☐ Yes ☐ No
  If yes, is there support of the use of opioids with a benzodiazepine? ☐ Yes ☐ No

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

TOLL FREE

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