OPIOIDS ER
PRIOR AUTHORIZATION/MEDICAL NECESSITY DETERMINATION
PRESCRIBER FAX FORM

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

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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 diagnosis:

- ☐ Chronic cancer pain due to active malignancy
- ☐ Chronic non-cancer pain
- ☐ Other (ICD code and description):_____

Medication requested:	Strength:
Dosing schedule:	Quantity per month:

All requests:

1. Is the patient currently taking the requested agent? ☐ Yes ☐ No
   If yes, is the patient at risk if therapy is changed? ☐ Yes ☐ No
2. Is the patient eligible for hospice care? ☐ Yes ☐ No
3. Has the prescriber counseled the patient on how to safely dispose of left-over medications to reduce the risk of diversion? ☐ Yes ☐ No
4. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
5. Is the patient concurrently taking a buprenorphine containing agent for opioid dependence treatment? ☐ Yes ☐ No
   If yes, is there information to support concurrent use of opioids with a buprenorphine containing agent for opioid dependence treatment? ☐ Yes ☐ No
6. Please explain why the patient needs the requested quantity (dose) for the requested indication: _____
   _____
7. Can the requested quantity (dose) be achieved with a lower quantity of a higher strength that does not exceed the quantity limit? ☐ Yes ☐ No
   If no, please explain why the requested dose cannot be optimized: _____
   _____

Chronic non-cancer pain requests:

8. Are there medical records showing a formal, consultative evaluation including diagnosis and a complete medical history which includes previous and current pharmacological and non-pharmacological therapy? **Please note, medical records are required.** ☐ Yes ☐ No
9. Is the requested agent being prescribed as an as-needed (prn) analgesic? ☐ Yes ☐ No
10. Has the patient had a trial of at least 7 days of an immediate-acting opioid? ☐ Yes ☐ No
    If no, does the patient have a documented intolerance, FDA labeled contraindication(s), or hypersensitivity to immediate-acting opioids? ☐ Yes ☐ No

Please continue on the next page.

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

11. Are there medical records showing the prescriber has a patient-specific pain management plan on file for the patient? **Please note, medical records are required.** ☐ Yes ☐ No
12. Has the prescriber confirmed that the patient is not diverting the requested agent, according to the patient's records in the state's prescription drug monitoring program (PDMP), if applicable? ☐ Yes ☐ No
13. Will the prescriber be conducting random urine drug screenings? ☐ Yes ☐ No
14. Are there medical records showing the patient's current medication list? **Please note, medical records are required.** ☐ Yes ☐ No
15. Is the patient's total MME > 90 mg per day? ☐ Yes ☐ No
    If yes, is there information about a treatment plan to reduce the MME to < 90 mg per day? ☐ Yes ☐ No
    If yes, please explain: _____
    _____
    If yes, is there information as to why the patient cannot tolerate a reduction in the MME? ☐ Yes ☐ No
    If yes, please explain: _____
    _____
16. Is the patient on multiple long-acting opioid formulations chronically? ☐ Yes ☐ No
17. Has the prescriber formally evaluated the patient's risk of overdose and offered naloxone if applicable? ☐ Yes ☐ No

Oxycontin (brand) and oxycodone ER (generic) requests:

18. Are there medical records showing the patient has tried and failed Xtampza? **Please note, medical records are required.** ☐ Yes ☐ No
    If no, are there medical records showing the patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to Xtampza? **Please note, medical records are required.** ☐ Yes ☐ No

Tramadol or tapentadol requests:

19. If the patient is outside the FDA approved age range, is the patient currently stabilized on the requested agent and has been on therapy for a minimum of 90 days and discontinuing treatment could potentially cause harm or a health risk? ☐ Yes ☐ No

Renewal requests:

20. Is the patient undergoing treatment for chronic non-cancer pain? ☐ Yes ☐ No
    If yes, is the requested agent being prescribed as an as-needed (prn) analgesic? ☐ Yes ☐ No
    If yes, has the prescriber confirmed that the patient is not diverting the requested agent, according to the patient's records in the state's prescription drug monitoring program (PDMP), if applicable? ☐ Yes ☐ No
    If yes, will the prescriber be conducting random urine drug screens? ☐ Yes ☐ No
    If yes, is the patient on multiple long-acting opioid formulations chronically? ☐ Yes ☐ No
    If yes, has the prescriber formally evaluated the patient's risk of overdose and offered naloxone, if applicable? ☐ Yes ☐ No

Please fax or mail this form to:
Horizon Blue Cross Blue Shield of New Jersey
c/o Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE
Fax: 877.897.8808 Phone: 888.214.1784

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