EXTENDED-RELEASE OPIOIDS
QUANTITY EXCEPTION
PRESCRIBER FAX FORM

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

The following documentation is REQUIRED for prior authorization. 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 the Blue Cross and Blue Shield of Kansas website at http://www.bcbsks.com

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:
- ☐ Active cancer pain due to an 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 being treated with the requested agent? ☐ Yes ☐ No
2. Does the requested agent contain tramadol, dihydrocodeine, or codeine? ☐ Yes ☐ No
   If yes and the patient is 12 to less than 18 years of age, will the requested opioid be used for post-operative pain management following a tonsillectomy and/or adenoidectomy? ☐ Yes ☐ No
3. Is the member eligible for hospice or palliative care? ☐ Yes ☐ No
4. Can the requested quantity (dose) be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit? ☐ Yes ☐ No
   If no, please explain: _____
   _____
5. Is there information to support therapy with a higher dose (quantity) for the requested indication? ☐ Yes ☐ No
   If yes, please explain: _____
   _____

Chronic non-cancer pain requests:

6. Has a formal, consultative evaluation been conducted that includes ALL of the following: 1) diagnosis, 2) a complete medical history which includes previous and current pharmacological and non-pharmacological therapy, and 3) the need for continued opioid therapy has been assessed? ☐ Yes ☐ No
7. Is there a patient-specific pain management plan on file for the patient? ☐ Yes ☐ No
8. Is the patient diverting controlled substances, according to the patient's records in the state's prescription drug monitoring program (PDMP), if applicable? ☐ Yes ☐ No

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE
Fax: 877.480.8130 Phone: 866.469.5660

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