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 <u>REQUIRED</u> 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 <u>www.covermymeds.com</u> For formulary information, please visit the Blue Cross and Blue Shield of Kansas website at <u>http://www.bcbsks.com</u>

Patient Name (First): Last: Mt: DOB (mm/dd/yyyy): Patient Address: City, State, Zip: Patient Telephone: Member ID Number: Group Number: Contact Name: Prescriber Name: Prescriber NPI#: Specialty: Contact Name: Clinic Name: Clinic Address: Contact Name: Contact Name: Clinic Name: Clinic Address: Secure Fax #: PECACE Contact Name: PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST Patient diagnosis: Contact Name: Chronic non-cancer pain Chronic non-cancer pain Cuantity per month: Patient Requested: Dosing schedule: Quantity per month: Patient requested agent? Yes No 1. Is the patient currently being treated with the requested agent? Yes No No No 2. Does the requested quantity (dose) be achieved with a lower quantity of a higher strength that does Yes No 3. Is the member eligible for hospice or palinative care? Is of the requested quantity (dose) be achieved with a lower quantity of a higher strength that does Yes No 4. Is there information to support therapy with a higher dose (quantity) for the requested nono-pharmacological therapy, and 3 the need	PATIENT AND INSURANCE INFORM		Today's Date:							
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 5. Is there information to support therapy with a higher dose (quantity) for the requested indication?	not exceed the program quantity limit?									
If yes, please explain:	If no, please explain:									-
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?										∐ No
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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? Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the						•			ia al	
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