OPIOIDS ER (EXTENDED RELEASE)
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber or clinic personnel 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 the Blue Cross Blue Shield of North Dakota web site at *www.bcbsnd.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:

- ☐ Chronic cancer pain due to an active malignancy
- ☐ Eligible for hospice OR palliative care
- ☐ Sickle cell disease
- ☐ Chronic non-cancer pain
- ☐ Other (ICD code and description):

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

All requests:

1. Is the patient currently using the requested agent? ☐ Yes ☐ No
2. Has the patient been treated with the requested agent within the past 90 days? ☐ Yes ☐ No
   If yes, is the patient at risk if therapy is changed? ☐ Yes ☐ No
   If yes, please explain: _____
   _____
3. Is the patient eligible for hospice OR palliative care? ☐ Yes ☐ No
4. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
5. Can the requested quantity (dose) be achieved with a lower quantity of a higher strength? ☐ Yes ☐ No
   If no, please explain: _____
   _____
   Please give information in support of therapy with a higher dose for the requested indication: _____
   _____
   _____
6. Does the requested agent contain tramadol, dihydrocodeine, or codeine? ☐ Yes ☐ No

Please continue to the next page.

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

If yes, is the patient 12 to less than 18 years of age? ☐ Yes ☐ No

If yes, will the requested agent be used for post-operative pain management following a tonsillectomy and/or adenoidectomy? ☐ Yes ☐ No

For brand Butrans, Duragesic, Hysingla, Kadian, MS Contin, Zohydro requests:

Brand	Generic Equivalent
Butrans	Buprenorphine patch
Duragesic	Fentanyl patch
Hysingla	Hydrocodone ER tabs
Kadian	Morphine sulfate ER caps
MS Contin	Morphine sulfate ER tabs
Zohydro	Hydrocodone ER caps

7. Does the patient have an intolerance or hypersensitivity to the generic equivalent that is not expected to occur with the brand agent? ☐ Yes ☐ No

If yes, please explain: _____

_____

If no, does the patient have an FDA labeled contraindication to the generic equivalent that is not expected to occur with the brand agent? ☐ Yes ☐ No

If yes, please explain: _____

_____

If no, is there information to support the use of the requested brand agent over the generic equivalent? ☐ Yes ☐ No

8. Is the patient undergoing treatment of chronic non-cancer pain? ☐ Yes ☐ No

If yes, please answer the following questions:

Is the patient concurrently using buprenorphine or buprenorphine/naloxone for opioid dependence treatment? ☐ Yes ☐ No

If yes, please provide information in support of use of concurrent use of opioids with buprenorphine or buprenorphine/naloxone for opioid dependence treatment: _____

_____

Has a formal, consultative evaluation which includes ALL of the following been conducted: 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

Is the requested agent prescribed as an as-needed (prn) analgesic? ☐ Yes ☐ No

Does the patient's medication history include a trial of at least 7 days of an immediate-acting opioid? ☐ Yes ☐ No

If no, does the patient have an intolerance or hypersensitivity to therapy with immediate-acting opioids that is not expected to occur with the requested agent? ☐ Yes ☐ No

If yes, please explain: _____

_____

If no, does patient have an FDA labeled contraindication to ALL immediate-acting opioids that is not expected to occur with the requested agent? ☐ Yes ☐ No

If yes, please explain: _____

_____

Is a patient-specific pain management plan on file for the patient? ☐ Yes ☐ No

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 ☐ NA

Please fax or mail this form to: Prime Therapeutics LLC	**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

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