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 within the past 90 days? ☐ Yes ☐ No
   If yes, is the patient at risk if therapy is changed? ☐ Yes ☐ No
2. Is the patient eligible for hospice OR palliative care? ☐ Yes ☐ No
3. Does the patient have sickle cell disease? ☐ Yes ☐ No
4. Has the prescriber counseled the patient on how to safely dispose of left-over medications to reduce the risk of diversion? ☐ Yes ☐ No
5. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify contraindications: _____
   _____
6. Is the patient concurrently using an agent containing buprenorphine for opioid dependence treatment? ☐ Yes ☐ No
   If yes, is there information to support concurrent use of opioids with an agent containing buprenorphine for opioid dependence treatment? ☐ Yes ☐ No
7. Please explain why the patient needs the requested quantity (dose) for the requested indication: _____
   _____
8. Can the requested quantity (dose) be achieved with a lower quantity of a higher strength? ☐ Yes ☐ No
   If no, please explain why the requested dose cannot be optimized: _____
   _____

Chronic non-cancer pain requests:

9. Is patient undergoing treatment for chronic non-cancer pain and there are medical records showing a formal, consultative evaluation which includes ALL of the following: 1) a 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? **Medical records are required.** ☐ Yes ☐ No
10. Is the requested agent being prescribed as an as-needed (prn) analgesic? ☐ Yes ☐ No

Please continue to the next page.

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

11. Has the patient had 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 intolerance or hypersensitivity _____
    _____
    If no, does the 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 specify contraindication: _____
    _____
12. Are there medical records showing the prescriber has a patient-specific pain management plan on file for the patient? **Medical records are required.** ☐ Yes ☐ No
13. Has the prescriber reviewed the patient's records in the state's prescription drug monitoring program (PDMP), AND has determined that the opioid dosages and combinations of opioids and other controlled substances within the patient's records do NOT indicate the patient is at high risk for overdose? ☐ Yes ☐ No
14. Will the prescriber be conducting random urine drug screenings? ☐ Yes ☐ No
15. Are there medical records showing the patient's current medication list? **Medical records are required.** ☐ Yes ☐ No
16. Is the patient's total MME greater than 50 mg per day? ☐ Yes ☐ No
    If yes, please provide information about a treatment plan to reduce the MME to less than 50 mg per day: _____
    _____
    If yes, is there information as to why the patient cannot tolerate a reduction in the MME? ☐ Yes ☐ No
    If yes, please explain: _____
    _____
17. Is the patient on multiple long-acting opioid formulations chronically? ☐ Yes ☐ No
18. Has the prescriber formally evaluated the patient's risk of overdose and offered naloxone if applicable? ☐ Yes ☐ No

Brand Butrans requests:

19. Is there documentation of a MedWatch form (http://www.fda.gov/media/76299/download) showing the patient has a severe (life threatening, required hospitalization, caused disability/permanent damage, required intervention to prevent permanent impairment/damage) intolerance or hypersensitivity to the generic equivalent (buprenorphine patch) that is not expected to occur with the brand agent? **A copy of the MedWatch form is required.** ☐ Yes ☐ No
    If no, does the patient have an FDA labeled contraindication to the generic equivalent (buprenorphine patch) that is not expected to occur with the brand agent? **Medical records are required.** ☐ Yes ☐ No
    If no, is there information provided to support the use of the requested agent over the generic equivalent? **Medical records are required.** ☐ Yes ☐ No

Brand Duragesic requests:

20. Is there documentation of a MedWatch form (http://www.fda.gov/media/76299/download) showing the patient has a severe (life threatening, required hospitalization, caused disability/permanent damage, required intervention to prevent permanent impairment/damage) intolerance or hypersensitivity to the generic equivalent (buprenorphine patch) that is not expected to occur with the brand agent? **A copy of the MedWatch form is required.** ☐ Yes ☐ No
    If no, does the patient have an FDA labeled contraindication to the generic equivalent (fentanyl patch) that is not expected to occur with the brand agent? **Medical records are required.** ☐ Yes ☐ No
    If no, is there information provided to support the use of the requested agent over the generic equivalent? **Medical records are required.** ☐ Yes ☐ No

Please continue to the next page.

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

Brand Hysingla requests:

21. Is there documentation of a MedWatch form (http://www.fda.gov/media/76299/download) showing the patient has a severe (life threatening, required hospitalization, caused disability/permanent damage, required intervention to prevent permanent impairment/damage) intolerance or hypersensitivity to the generic equivalent (buprenorphine patch) that is not expected to occur with the brand agent? **A copy of the MedWatch form is required.** ..... ☐ Yes ☐ No

    If no, does the patient have an FDA labeled contraindication to the generic equivalent (hydrocodone ER tabs) that is not expected to occur with the brand agent? **Medical records are required.** ..... ☐ Yes ☐ No

        If no, is there information provided to support the use of the requested agent over the generic equivalent? **Medical records are required.** ..... ☐ Yes ☐ No

Brand MS Contin requests:

22. Is there documentation of a MedWatch form (http://www.fda.gov/media/76299/download) showing the patient has a severe (life threatening, required hospitalization, caused disability/permanent damage, required intervention to prevent permanent impairment/damage) intolerance or hypersensitivity to the generic equivalent (buprenorphine patch) that is not expected to occur with the brand agent? **A copy of the MedWatch form is required.** ..... ☐ Yes ☐ No

    If no, does the patient have an FDA labeled contraindication to the generic equivalent (morphine sulfate tablets) that is not expected to occur with the brand agent? **Medical records are required.** ..... ☐ Yes ☐ No

        If no, is there information provided to support the use of the requested agent over the generic equivalent? **Medical records are required.** ..... ☐ Yes ☐ No

Brand Zohydro requests:

23. Is there documentation of a MedWatch form (http://www.fda.gov/media/76299/download) showing the patient has a severe (life threatening, required hospitalization, caused disability/permanent damage, required intervention to prevent permanent impairment/damage) intolerance or hypersensitivity to the generic equivalent (buprenorphine patch) that is not expected to occur with the brand agent? **A copy of the MedWatch form is required.** ..... ☐ Yes ☐ No

    If no, does the patient have an FDA labeled contraindication to the generic equivalent (hydrocodone ER capsules) that is not expected to occur with the brand agent? **Medical records are required.** ..... ☐ Yes ☐ No

        If no, is there information provided to support the use of the requested agent over the generic equivalent? **Medical records are required.** ..... ☐ Yes ☐ No

Oxycontin or generic oxycodone ER requests:

24. Are there medical records showing the patient has tried and failed Xtampza? **Medical records are required.** ..... ☐ Yes ☐ No

    If no, are there medical records showing the patient has an intolerance or hypersensitivity to Xtampza? **Medical records are required.** ..... ☐ Yes ☐ No

        If no, are there medical records showing the patient has an FDA labeled contraindication to Xtampza? **Medical records are required.** ..... ☐ Yes ☐ No

Agents containing tramadol, codeine, dihydrocodeine, or tapentadol requests:

25. If the patient is outside the FDA approved age range for the requested indication, 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

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