OPIOIDS (EXTENDED RELEASE)
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

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

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information please visit *www.myprime.com*.

What is the priority level of this request?

☐ Standard
☐ Date of service (if applicable): ___________________
☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

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 #:	

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

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's Diagnosis:

☐ Chronic cancer pain due to active malignancy
☐ Chronic non-cancer pain
☐ Post-operative pain management following tonsillectomy and/or adenoidectomy
☐ Other (ICD code plus description): ____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? .... ☐ Yes ☐ No
2. Has the patient been treated with the requested agent in the past 90 days? .... ☐ Yes ☐ No
   If yes, is the patient at risk if therapy with the requested agent is changed? .... ☐ Yes ☐ No
   If yes, please explain: ____
   ____
3. Is the patient eligible for hospice care? .... ☐ Yes ☐ No
4. Is the patient concurrently taking a buprenorphine or buprenorphine/naloxone agent for opioid dependence treatment? .... ☐ Yes ☐ No
   If yes, please provide supporting explanation: ____
   ____
5. Does the patient have any FDA labeled contraindications to the requested agent? .... ☐ Yes ☐ No

Please continue to the next page.

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

6. Please list all reasons for selecting the requested medication, strength, dosing schedule and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). ____

____

7. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products.)

______________________ Date(s): __________ ______________________ Date(s): __________
______________________ Date(s): __________ ______________________ Date(s): __________
______________________ Date(s): __________ ______________________ Date(s): __________

For chronic non-cancer pain:

8. Is the patient undergoing treatment for chronic non-cancer pain? ☐ Yes ☐ No
   If yes, has the patient had a formal, consultative evaluation which includes ALL of the following: 1) diagnosis, 2) 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
9. Is the requested agent being prescribed as an as-needed (PRN) analgesic? ☐ Yes ☐ No
10. Does the patient's medication history include at least a 7 days trial of an immediate-acting opioid? ☐ Yes ☐ No
   If no, does the patient have an intolerance or hypersensitivity to immediate-acting opioids that is not expected to occur with the requested agent? ☐ Yes ☐ No
      If yes, please explain: ____

      ____

      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 explain: ____

         ____
11. Is there a patient-specific pain management plan is on file for the patient? ☐ Yes ☐ No
12. Is the patient diverting the requested medication, 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

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BCBSNJ:	**888.214.1784**	**Fax: 855.212.8110**
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