OPIOID ER
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber 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 *www.regence.com.* To submit this form electronically, please go to covermymeds.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's 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 - ICD code plus description**:**	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

1. Is the patient currently treated with the requested medication? ..... ☐ Yes ☐ No

   If yes, when was treatment with the requested medication started? _____

2. 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). _____

   _____

   _____

3. Does the patient have a diagnosis of chronic cancer pain due to an active malignancy? ..... ☐ Yes ☐ No
4. Is the patient eligible for hospice care (defined as having a terminal illness with a life expectancy of 6 months or less if the illness runs its normal course)?..... ☐ Yes ☐ No
5. Does the patient have a diagnosis of sickle cell disease? ..... ☐ Yes ☐ No
6. Is the patient undergoing treatment of chronic non-cancer pain? ..... ☐ Yes ☐ No
7. Is the request for treatment of acute non-cancer pain (including, but not limited to post-surgical pain)? .. ☐ Yes ☐ No
8. Is the requested medication prescribed as an as-needed (prn) analgesic? ..... ☐ Yes ☐ No
9. Does the patient's medical history include a 7-day trial of an immediate-release (short acting) opioid? ... ☐ Yes ☐ No

   If no, does the patient have a documented intolerance, FDA labeled contraindication, or hypersensitivity to immediate-release (short acting) opioid? ..... ☐ Yes ☐ No

   If yes, please explain: _____

Please continue to the next page.

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

10. Has a comprehensive evaluation of what is causing the pain been performed? ..... ☐ Yes ☐ No

Please provide supporting clinical documentation (including, but not limited to chart notes).

11. Is there a patient-specific comprehensive pain management treatment plan that addresses patient specific goals of opioid therapy on file for this patient? The treatment plan includes, but is not limited to, a plan to get to the lowest effective opioid dose in the shortest time. ..... ☐ Yes ☐ No

Please provide supporting clinical documentation (including, but not limited to chart notes).

12. Has therapy with other pain management treatments been maximized and documented as insufficient for control of pain? ..... ☐ Yes ☐ No

Other pain management treatments include: non-pharmacological therapy such as 1) exercise, such as regular walks, swimming, stretching, yoga, physical therapy, and physical rehabilitation, 2) relaxation techniques such as meditation, yoga, tai chi, deep breathing, visualization, listening to soothing music, and progressive muscle relaxation and 3) other options such as heat/cold therapy, massage, psychological therapy, cognitive behavioral therapy, weight loss, or biofeedback AND non-opioid therapy (such as acetaminophen, NSAIDs, antiepileptics, and antidepressants).

If no, are other pain management treatments medically contraindicated for this patient? ..... ☐ Yes ☐ No

If yes, please explain: _____

Renewal Requests

For non-cancer related pain:

13. Has the patient's comprehensive pain management treatment plan been assessed and updated and the patient is making progress toward the stated goals of opioid therapy? ..... ☐ Yes ☐ No

Please provide supporting clinical documentation (including, but not limited to chart notes).

For cancer related pain or eligibility for hospice:

14. Does the patient have ongoing pain due to an active malignancy or eligibility for hospice? ..... ☐ Yes ☐ No

Please provide supporting clinical documentation (including, but not limited to chart notes).

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

TOLL FREE

Fax: 855.212.8110 **Phone: 888.216.6710**