OPIOIDS (EXTENDED RELEASE)
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

WYOMING
An independent licensee of the Blue Cross and Blue Shield Association

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 Preferred Drug List information, please visit www.myprime.com or the Blue Cross and Blue Shield of Wyoming web site at www.bcbswy.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'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. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify contraindication(s): _____
4. Is the patient 18 years of age or older? ☐ Yes ☐ No
   If no, is the patient 12 years or older but 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
5. Is the patient eligible for hospice OR palliative care? ☐ Yes ☐ No
6. Will the patient be concurrently using buprenorphine or buprenorphine/naloxone for opioid dependence treatment? ☐ Yes ☐ No
   If yes, is there information in support of concurrent use of opioids with buprenorphine or buprenorphine/naloxone for opioid dependence treatment? ☐ Yes ☐ No
   If yes, please provide supporting information: _____

Please continue to the next page.

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

7. 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). _____
_____
_____

8. 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:

9. 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
10. Is there a patient-specific pain management plan is on file for the patient? ..... ☐ Yes ☐ No
11. Is the requested agent being prescribed as an as-needed (PRN) analgesic? ..... ☐ Yes ☐ No
12. Does the patient's medical 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 immediate-acting opioids that is not expected to occur with the requested agent? ..... ☐ Yes ☐ No

    If yes, please explain intolerance/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(s): _____
    _____

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

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

14. 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 intolerance/hypersensitivity: _____
    _____

    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 specify contraindication(s): _____
    _____

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

    If yes, please provide supporting information: _____
    _____

Please fax or mail this form to:
Blue Cross Blue Shield of Wyoming
Medical Review Department
PO Box 2266
Cheyenne, Wyoming 82003-2266

TOLL FREE
Fax: 307.635.3916 Phone: 800.442.2376