BlueCross BlueShield of North Carolina

# Opioids ER- Belbuca
## Prior Authorization (PA) Request Form

To submit request electronically, please go to covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: 888-446-8535

Mail: Blue Cross NC, ATTN: Part D Coverage Determination
P.O. Box 17509, Winston Salem, NC 27116-7509

Call: 888-298-7552 Blue Medicare Rx
888-296-9790 Blue Medicare HMO/PPO

**Incomplete Form May Delay Processing**

| Prescriber Information | | Patient Information |
|---|---|---|
| Physician Name: | NPI #: | Patient Name: |
| Office Contact Person: | | Patient ID #: |
| Office Phone #: | Office Fax #: | Home Phone #: |
| Address: | | Sex: ☐ Female ☐ Male |
| City: State: Zip: | | DOB: |

| Diagnosis and Medication Information | |
|---|---|
| Medication Requested: | Diagnosis Code: |
| Strength and Route of Administration: | Dosing Schedule: |
| Quantity per 30 Days: | |

**Please answer questions below**

1. Is this request for an expedited review?..... ☐ Yes ☐ No
   ***Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.*** *A standard review will have a decision made within 72 hours for a coverage determination.*

2. Please select the diagnosis for the requested medication and answer any associated questions:
   - ☐ **Chronic cancer pain due to an active malignancy**
   - ☐ **Chronic non-cancer pain**
     - A. Has the patient been treated with the requested medication within the past 90 days?..... ☐ Yes ☐ No
       **If NO**, please answer the following questions:
       - i. Is a patient-specific pain management plan on file for this patient?..... ☐ Yes ☐ No
         - a. **If YES,** please submit documentation of a formal, consultative evaluation, including diagnosis and a complete medical history which includes previous and current pharmacological and non-pharmacological therapy.
       - ii. Is the requested medication being prescribed as an as-needed (prn) analgesic?..... ☐ Yes ☐ No
       - iii. Does the patient's medication history include use of an immediate-acting opioid, OR does the patient have a documented intolerance, FDA labeled contraindication, or hypersensitivity to immediate-acting opioids?..... ☐ Yes ☐ No
       - iv. Has the prescriber confirmed that the patient is not diverting the requested medication, according to the patient's records in the state's prescription drug monitoring program (PDMP)?..... ☐ Yes ☐ No
       - v. Does the patient have acute or severe bronchial asthma?..... ☐ Yes ☐ No
         - a. **If YES,** will the patient be in a monitored setting and have access to resuscitative equipment?..... ☐ Yes ☐ No
       - vi. Does the patient have significant respiratory depression?..... ☐ Yes ☐ No
       - vii. Does the patient have known or suspected gastrointestinal obstruction?..... ☐ Yes ☐ No
       - viii. Does the patient have known or suspected paralytic ileus?..... ☐ Yes ☐ No

**PLEASE CONTINUE TO NEXT PAGE**

☐ **Other (please specify):** _____

3. Is the requested quantity *greater* than the set quantity limit #60 films per 30 days?.....☐ Yes ☐ No
   A. **If YES,** please provide a clinical rationale in support of the quantity requested, including length of time the requested dose has been used (may submit medical records to support this request):_____
   _____
   _____

I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature:_____ Date: _____