BlueCross BlueShield of North Carolina

Extended-Release Opioid Analgesics – Enhanced Formulary

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]	
CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX	
PRESCRIBER ADDRESS	CITY	STATE	ZIP
PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER M F

Diagnosis Code: ____________

Please select the requested medication and answer the following questions for INITIAL coverage:

See pages 3-4 for continuation coverage

☐ Belbuca™	☐ fentanyl transdermal patch (37.5mcg/hr)	☐ morphine sulfate beads ER capsule	☐ brand Oxycontin®
☐ brand Butrans®	☐ fentanyl transdermal patch (62.5mcg/hr)	☐ brand MS Contin	☐ tramadol ER capsule (generic Conzip)
☐ buprenorphine buccal film (generic Belbuca)	☐ fentanyl transdermal patch (87.5mcg/hr)	☐ morphine sulfate ER tablet (generic MS Contin)	☐ tramadol ER tablet (generic Ultram ER)
☐ buprenorphine transdermal system (generic Butrans)	☐ hydrocodone ER abuse deterrent capsules (generic Zohydro® ER)	☐ Nucynta® ER	☐ tramadol SR biphasic tablet (generic Ryzolt)
☐ Conzip®	☐ hydrocodone ER tablets (generic Hysingla® ER)	☐ oxymorphone ER	☐ brand Ultram® ER
☐ brand Duragesic®	☐ hydromorphone ER (generic Exalgo)	☐ oxycodone ER tablet (generic OxyContin)	☐ Xtampza™ ER
☐ Exalgo®	☐ Hysingla® ER	☐ oxymorphone ER tablet (generic Opana ER)	☐ Zohydro® ER
☐ fentanyl transdermal patch (generic Duragesic)	☐ morphine sulfate ER capsule (generic Kadian)		

1. Is the requested medication Oxycontin or oxycodone ER (authorized generic Oxycontin)?.....☐ Yes ☐ No
   a. **If YES,** has the patient tried and failed or is intolerant to, or has a contraindication to Xtampza ER?........☐ Yes ☐ No
   If YES, please submit medical record documentation.
2. Is the patient currently taking the requested medication?........☐ Yes ☐ No
3. Does the patient have a diagnosis of chronic cancer pain due to an active malignancy?.........☐ Yes ☐ No
4. Does the patient have a diagnosis of sickle cell disease?........☐ Yes ☐ No
5. Is the patient eligible for hospice care?........☐ Yes ☐ No
6. Is the patient receiving palliative care?........☐ Yes ☐ No

****continued on page 2; please complete and sign page 2 to request prior authorization****

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Extended-Release Opioid Analgesics – Enhanced (*continued*)

7. Is the patient undergoing treatment of chronic non-cancer pain?..☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Is a patient specific pain management plan on file for the patient?..............................☐ Yes ☐ No
   b. Has the patient exhausted other pharmacological and non-pharmacological therapy appropriate for the condition?...☐ Yes ☐ No
   c. Does the patient have a diagnosis of chronic neuropathic pain?.................................☐ Yes ☐ No
      If YES, please answer the following questions:
      i. Has the patient had a trial and failure of any of the following medication classes:
         1. GABA analogue [gabapentin (Neurontin®) or pregabalin (Lyrica®)]?.........☐ Yes ☐ No
         2. SNRI [duloxetine (Cymbalta®) or milnacipran (Savella®)]?........................☐ Yes ☐ No
         3. tricyclic antidepressant (e.g., amitriptyline)?..☐ Yes ☐ No
      ii. Does the patient have a contraindication to any of the following medication classes:
         1. GABA analogue [gabapentin (Neurontin®) or pregabalin (Lyrica®)]?.........☐ Yes ☐ No
         2. SNRI [duloxetine (Cymbalta®) or milnacipran (Savella®)]?........................☐ Yes ☐ No
         3. tricyclic antidepressant (e.g., amitriptyline)?..☐ Yes ☐ No
   d. Is the requested medication prescribed as an as-needed analgesic (for PRN use)?....☐ Yes ☐ No
   e. Does the patient's medication history include at least a 7-day trial of an immediate acting opioid?..☐ Yes ☐ No
      i. **If NO,** please provide a clinical explanation why the patient is unable to use immediate acting opiates prior to taking an ER opiate and **attach supporting medication records**:
      ____
      ____
   f. Has the prescriber reviewed the patient's controlled substance use in the state's prescription drug monitoring system (PDMP) within the last 90 days?.........................☐ Yes ☐ No
   g. Is the patient concurrently using a buprenorphine product for opioid dependence (i.e., Suboxone, Subutex, buprenorphine/naloxone, etc.)?..☐ Yes ☐ No
   h. Will the patient be taking the requested medication with another ER opiate?...............☐ Yes ☐ No
   i. Will the patient be taking the requested medication with a benzodiazepine?...............☐ Yes ☐ No
      a. **IF YES**, please provide a clinical rationale supporting the use of a benzodiazepine in combination with an extended release opioid (*omission of information indicates N/A or none*):____
      ____

****PLEASE NOTE: If you are prescribing more than the program quantity limit (listed on pages 6-8) please complete and sign* ***page 5*** *****

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my 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. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):________________________________ **Date**:___________

For Blue Cross NC members, fax form to 1-800-795-9403

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PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]	
CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX	
PRESCRIBER ADDRESS	CITY	STATE	ZIP
PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER M F

Diagnosis Code: ____________

Please select the requested medication and answer the following questions for CONTINUATION coverage:

☐ Belbuca™	☐ fentanyl transdermal patch (37.5mcg/hr)	☐ morphine sulfate beads ER capsule	☐ brand Oxycontin®
☐ brand Butrans®	☐ fentanyl transdermal patch (62.5mcg/hr)	☐ brand MS Contin	☐ tramadol ER capsule (generic Conzip)
☐ buprenorphine buccal film (generic Belbuca)	☐ fentanyl transdermal patch (87.5mcg/hr)	☐ morphine sulfate ER tablet (generic MS Contin)	☐ tramadol ER tablet (generic Ultram ER)
☐ buprenorphine transdermal system (generic Butrans)	☐ hydrocodone ER abuse deterrent capsules (generic Zohydro® ER)	☐ Nucynta® ER	☐ tramadol SR biphasic tablet (generic Ryzolt)
☐ Conzip®	☐ hydrocodone ER tablets (generic Hysingla® ER)	☐ oxymorphone ER	☐ brand Ultram® ER
☐ brand Duragesic®	☐ hydromorphone ER (generic Exalgo)	☐ oxycodone ER tablet (generic OxyContin)	☐ Xtampza™ ER
☐ Exalgo®	☐ Hysingla® ER	☐ oxymorphone ER tablet (generic Opana ER)	☐ Zohydro® ER
☐ fentanyl transdermal patch (generic Duragesic)	☐ morphine sulfate ER capsule (generic Kadian)		

1. Has the requested medication been approved through initial coverage review with Blue Cross NC for the current source of chronic pain?........ ☐ Yes ☐ No
   If NO, please answer all questions on pages 1-2.
2. Is the requested medication Oxycontin or oxycodone ER (authorized generic Oxycontin)?..... ☐ Yes ☐ No
   a. **If YES,** has the patient tried and failed or is intolerant to, or has a contraindication to Xtampza ER?........ ☐ Yes ☐ No
   If YES, please submit medical record documentation.
3. Does the patient have a diagnosis of chronic cancer pain due to an active malignancy?......... ☐ Yes ☐ No
4. Does the patient have a diagnosis of sickle cell disease?........ ☐ Yes ☐ No
5. Is the patient eligible for hospice care?........ ☐ Yes ☐ No
6. Is the patient receiving palliative care?........ ☐ Yes ☐ No

****continued on page 4; please complete and sign page 4 to request prior authorization****

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Extended-Release Opioid Analgesics – Enhanced (*continued*)

7. Is the patient undergoing treatment of chronic non-cancer pain?..☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Has the prescriber reviewed the patient's controlled substance use in the state's prescription drug monitoring system (PDMP) within the last 90 days?..........................☐ Yes ☐ No
   b. Is the patient concurrently using a buprenorphine product for opioid dependence (i.e., Suboxone, Subutex, buprenorphine/naloxone, etc.)?..☐ Yes ☐ No
   c. Will the patient be taking the requested medication with another ER opiate?..............☐ Yes ☐ No
   d. Will the patient be taking the requested medication with a benzodiazepine?................☐ Yes ☐ No
      i. **IF YES,** please provide a clinical rationale supporting the use of a benzodiazepine in combination with an extended-release opioid *(omission of information indicates N/A or none)*: ____
      ____
   e. Is the prescriber re-evaluating the benefits and harms of continued opioid treatment with the patient at least every 3 months?...☐ Yes ☐ No

*******PLEASE NOTE: If you are prescribing more than the program quantity limit (listed on pages 6-8) please complete and sign*** **page 5** *****

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my 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. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):______________________________ **Date**:__________

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COMPLETE PAGE 5 ONLY IF REQUESTING A QUANTITY LIMIT EXCEPTION FOR EXTENDED-RELEASE OPIOID ANALGESICS

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]	
CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX	
PRESCRIBER ADDRESS	CITY	STATE	ZIP
PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER M F

FOR COVERAGE OVER THE QUANTITY LIMITS (PROGRAM MAXIMUM PER DAY OR MAXIMUM PROGRAM LIMITS) LISTED ON PAGES 6-8, PLEASE ANSWER THE FOLLOWING:

Please note: This medication requires a prior authorization before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (pages 1-2 or pages 3-4). Otherwise, this request will deny.

Diagnosis Code:______________

Medication Name and Strength: ____________________________ **Requested Quantity per day:** ___________
****Please enter quantity as a numeric value with one decimal place (ex. 1.0, 1.5)****

In the space provided, please document support for the requested Quantity Limit Exception (this may include documented clinical rationale and/or medical records). **Rationale must be submitted.**

____
____
____

Please certify the following by signing and dating below:
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Prescriber's Signature (Required):_____________________________________ **Date**:___________

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QUANTITY LIMITATIONS

NOTE: quantity limits apply to both brand and generic formulations

Medication	Quantity per Day (unless specified)	Program Maximum per Day (unless specified)
Belbuca (buprenorphine) 75 mcg buccal film	2	1800 mcg
Belbuca (buprenorphine) 150 mcg buccal film	2	
Belbuca (buprenorphine) 300 mcg buccal film	2	
Belbuca (buprenorphine) 450 mcg buccal film	2	
Belbuca (buprenorphine) 600 mcg buccal film	2	
Belbuca (buprenorphine) 750 mcg buccal film	2	
Belbuca (buprenorphine) 900 mcg buccal film	2	
Butrans (buprenorphine) 5 mcg/hour transdermal system	1 system/week	20mcg/hr. per week
Butrans (buprenorphine 7.5 mcg/hour transdermal system	1 system/week	
Butrans (buprenorphine) 10 mcg/hour transdermal system	1 system/week	
Butrans (buprenorphine) 15 mcg/hour transdermal system	1 system/week	
Butrans (buprenorphine) 20 mcg/hour transdermal system	1 system/week	
ConZip (tramadol SR biphasic) 100 mg capsule	1	300 mg
ConZip (tramadol SR biphasic) 200 mg capsule	1	
ConZip (tramadol SR biphasic) 300 mg capsule	1	
Duragesic (fentanyl transdermal patch) 12 mcg/hr. transdermal patch	15 patches/30 days	100mcg/hr. per 2 days
Duragesic (fentanyl transdermal patch) 25 mcg/hr. transdermal patch	15 patches/30 days	
Duragesic (fentanyl transdermal patch) 50 mcg/hr. transdermal patch	15 patches/30 days	
Duragesic (fentanyl transdermal patch) 75 mcg/hr. transdermal patch	15 patches/30 days	
Duragesic (fentanyl transdermal patch) 100 mcg/hr. transdermal patch	15 patches/30 days	
Exalgo (hydromorphone) 8 mg extended-release tablet	1	32 mg
Exalgo (hydromorphone) 12 mg extended-release tablet	1	
Exalgo (hydromorphone) 16 mg extended-release tablet	1	
Exalgo (hydromorphone) 32 mg extended-release tablet	1	
Fentanyl transdermal patch 37.5 mcg/hr. transdermal patch	15 patches/30 days	87.5mcg/ hr. per 2 days
Fentanyl transdermal patch 62.5 mcg/hr. transdermal patch	15 patches/30 days	
Fentanyl transdermal patch 87.5 mcg/hr. transdermal patch	15 patches/30 days	
Hysingla ER (hydrocodone) 20 mg extended-release tablet	1	120 mg
Hysingla ER (hydrocodone) 30 mg extended-release tablet	1	
Hysingla ER (hydrocodone) 40 mg extended-release tablet	1	
Hysingla ER (hydrocodone) 60 mg extended-release tablet	1	
Hysingla ER (hydrocodone) 80 mg extended-release tablet	1	

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Hysingla ER (hydrocodone) 100 mg extended-release tablet	1	
Hysingla ER (hydrocodone) 120 mg extended-release tablet	1	
Morphine sulfate ER 10 mg extended-release capsule	2	400 mg
Morphine sulfate ER 20 mg extended-release capsule	2	
Morphine sulfate ER 30 mg extended-release capsule	2	
Morphine sulfate ER 40 mg extended-release capsule	2	
Morphine sulfate ER 50 mg extended-release capsule	2	
Morphine sulfate ER 60 mg extended-release capsule	2	
Morphine sulfate ER 80 mg extended-release capsule	2	
Morphine sulfate ER 100 mg extended-release capsule	2	
Morphine Sulfate beads 30mg extended-release capsule	1	120 mg
Morphine Sulfate beads 45mg extended-release capsule	1	
Morphine Sulfate beads 60mg extended-release capsule	1	
Morphine Sulfate beads 75mg extended-release capsule	1	
Morphine Sulfate beads 90mg extended-release capsule	1	
Morphine Sulfate beads 120mg extended-release capsule	1	
MS Contin (morphine sulfate) 15 mg sustained-release tablet	3	600 mg
MS Contin (morphine sulfate) 30 mg sustained-release tablet	3	
MS Contin (morphine sulfate) 60 mg sustained-release tablet	3	
MS Contin (morphine sulfate) 100 mg sustained-release tablet	3	
MS Contin (morphine sulfate) 200 mg sustained-release tablet	3	
Nucynta ER (tapentadol SR) 50 mg extended-release tablet	2	500 mg
Nucynta ER (tapentadol SR) 100 mg extended-release tablet	2	
Nucynta ER (tapentadol SR) 150 mg extended-release tablet	2	
Nucynta ER (tapentadol SR) 200 mg extended-release tablet	2	
Nucynta ER (tapentadol SR) 250 mg extended-release tablet	2	
OxyContin (oxycodone ER) 10 mg tablet	2	160 mg
OxyContin (oxycodone ER) 15 mg tablet	2	
OxyContin (oxycodone ER) 20 mg tablet	2	
OxyContin (oxycodone ER) 30 mg tablet	2	
OxyContin (oxycodone ER) 40 mg tablet	2	
OxyContin (oxycodone ER) 60 mg tablet	2	
OxyContin (oxycodone ER) 80 mg tablet	2	
Oxymorphone ER, crush resistant 5 mg tablet	2	80 mg

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Oxymorphone ER, crush resistant 7.5 mg tablet	2	
Oxymorphone ER, crush resistant 10 mg tablet	2	
Oxymorphone ER, crush resistant 15 mg tablet	2	
Oxymorphone ER, crush resistant 20 mg tablet	2	
Oxymorphone ER, crush resistant 30 mg tablet	2	
Oxymorphone ER, crush resistant 40 mg tablet	2	
Tramadol ER (tramadol SR) 100 mg sustained-release tablet	1	300 mg
Tramadol ER (tramadol SR biphasic) 150 mg capsule	1	
Tramadol ER (tramadol SR) 200 mg sustained-release tablet	1	
Tramadol ER (tramadol SR) 300 mg sustained-release tablet	1	
Ultram ER (tramadol SR) 100 mg sustained-release tablet	1	300 mg
Ultram ER (tramadol SR) 200 mg sustained-release tablet	1	
Ultram ER (tramadol SR) 300 mg sustained-release tablet	1	
Xtampza ER (oxycodone ER abuse deterrent) 9 mg extended release capsule	2	288 mg
Xtampza ER (oxycodone ER abuse deterrent) 13.5 mg extended release capsule	2	
Xtampza ER (oxycodone ER abuse deterrent) 18 mg extended release capsule	2	
Xtampza ER (oxycodone ER abuse deterrent) 27 mg extended release capsule	2	
Xtampza ER (oxycodone ER abuse deterrent) 36 mg extended release capsule	8	
Zohydro ER (hydrocodone ER abuse deterrent) 10 mg sustained-release capsule	2	100 mg
Zohydro ER (hydrocodone ER abuse deterrent) 15 mg sustained-release capsule	2	
Zohydro ER (hydrocodone ER abuse deterrent) 20 mg sustained-release capsule	2	
Zohydro ER (hydrocodone ER abuse deterrent) 30 mg sustained-release capsule	2	
Zohydro ER (hydrocodone ER abuse deterrent) 40 mg sustained-release capsule	2	
Zohydro ER (hydrocodone ER abuse deterrent) 50 mg sustained-release capsule	2	

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