PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

# EXTENDED RELEASE OPIOID PRIOR AUTHORIZATION FORM

## PATIENT INFORMATION

| Subscriber's ID Number | | | Subscriber's Group Number |
|---|---|---|---|
| Patient's Name | | Phone | Date of Birth |
| Address | City | State | Zip Code |

## PRESCRBER INFORMATION

| Physician's Name | NPI | Phone | Fax |
|---|---|---|---|
| Address | City | State | Zip Code |
| Suite / Building | Physician's Signature | | Date |

## MEDICATION INFORMATION

| Diagnosis: | |
|---|---|
| Quantity: | Day Supply: |

## CLINICAL CRITERIA

1. Please check **ALL** that apply. The patient has pain associated with:

☐ Cancer (please provide diagnosis): _____
☐ Hospice program, end-of-life care, or palliative care (please provide diagnosis): _____
☐ Sickle cell anemia
☐ None of the above

2. Please check **ALL** that apply.

☐ The patient has pain severe enough to require daily, around-the-clock, long-term opioid treatment
☐ The patient is NOT opioid naïve
☐ At least one of the following therapies have been evaluated:
- Non-opioid medications (e.g. nonsteroidal anti-inflammatory drugs [NSAIDs], acetaminophen, tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors [SNRIs], anticonvulsants)
- Exercise therapy
- Physical therapy
- Weight loss
- Cognitive behavioral therapy

☐ The patient's history of controlled substance prescriptions has been checked using the state prescription drug monitoring program (PDMP)
☐ The patient or parent/guardian has been educated on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction

| | | |
|---|---|---|
| 3. Based on the patient's clinical circumstances, is the prescribed amount of opioid warranted in order to adequately manage the patient's pain? | Yes | No |
| 4. Is there an ongoing monitoring plan to identify and address drug-drug interactions between the requested opioid and any opioid potentiators (e.g. Gabapentin, Horizant, Gralise, Lyrica/Pregabalin, benzodiazepines, sedative-hypnotics, etc.)? | Yes | No |

5. Please provide any other medications previously tried and failed for the patient's diagnosis:

_____

_____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

## INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   **NOTE:** *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **Clinical Services,**
   **120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222**