

SHORT-ACTING OPIOID ANALGESICS PRIOR AUTHORIZATION FORM

(form effective 1/1/20)



Fax to PerformRxSM at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total # pages:	Name/phone of office or LTC facility contact:
PATIENT INFORMATION			
Patient name:		Patient ID#:	DOB:
Street address:		Apt. #:	City/state/zip:
PRESCRIBER INFORMATION			
Prescriber name:		Specialty:	NPI:
Street address:		Suite #:	City/state/zip:
Phone:		Fax:	
CLINICAL INFORMATION			
Drug:			
Strength:	Qty per fill:	to last days	Duration: days / 1 mo / 2 mos / 3 mos
Directions:			
Weight (if <21 yrs):	lbs / kg	Diagnosis (submit documentation):	Dx code (required):
1. Did the prescriber or prescriber's delegate search the PDMP to review the patient's controlled substance prescription history before issuing this prescription for the requested agent? <input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No		2. Is the patient taking a benzodiazepine? Submit patient's current medication list. <input type="checkbox"/> Yes – List and provide medical justification: <input type="checkbox"/> No	
3. Initial requests for all NON-PREFERRED medications: Does the patient have a history of trial and failure, contraindication, or intolerance to the preferred short-acting opioids analgesics? Check all that apply. <input type="checkbox"/> APAP/codeine tablet or elixir <input type="checkbox"/> hydrocodone/ibuprofen tablet <input type="checkbox"/> oxycodone IR tablet <input type="checkbox"/> Endocet <input type="checkbox"/> morphine IR tablet <input type="checkbox"/> oxycodone/APAP tablet <input type="checkbox"/> hydrocodone/APAP tablet <input type="checkbox"/> morphine solution or concentrate <input type="checkbox"/> tramadol IR tablet <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of trial & failure, contraindications, or intolerances.</i>			
4. What is the anticipated duration of therapy with opioid analgesics? Specify duration: <i>Submit documentation</i>			
5. Is the patient being treated for active cancer, sickle cell with crisis, or neonatal abstinence syndrome OR receiving hospice or palliative care services? <input type="checkbox"/> Yes – Submit documentation. <input type="checkbox"/> No – Continue to the next question.			
6. Check all of the following that apply to the Patient. Submit detailed medical record documentation for EACH item. INITIAL requests: <input type="checkbox"/> has documentation of a complete physical exam, including diagnostic testing/imaging results, and pain assessment (cause, severity, location, etc) <input type="checkbox"/> has tried or cannot try non-drug pain management modalities (eg, behavioral, cognitive, physical, and/or supportive therapies) <input type="checkbox"/> has tried or cannot try non-opioid drugs for the treatment of pain – check drugs tried: <input type="checkbox"/> acetaminophen <input type="checkbox"/> NSAIDs <input type="checkbox"/> other: _____ <input type="checkbox"/> the requested opioid medication will be used in combination with tolerated non-drug therapies and non-opioid medications <input type="checkbox"/> was assessed for the potential risk of misuse, abuse, and addiction based on family and social history obtained by prescriber <input type="checkbox"/> was counseled regarding potential side effects of opioids including risk of misuse, abuse, addiction (if <21 yo, parent/guardian may be counseled) <input type="checkbox"/> was assessed for recent (within the past 60 days) opioid use <input type="checkbox"/> was evaluated for risk factors for opioid-related harm <input type="checkbox"/> if identified to be at high risk for opioid-related harm, the prescriber considered prescribing naloxone <input type="checkbox"/> has a recent UDS testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, tramadol, and carisoprodol. Date of last UDS: _____ RENEWAL requests: <input type="checkbox"/> experienced an improvement in pain control and level of functioning while on the requested agent <input type="checkbox"/> the requested opioid medication will be used in combination with tolerated non-drug therapies and non-opioid medications <input type="checkbox"/> is being monitored by the prescriber for adverse events and warning signs of serious problems, such as overdose and opioid use disorder <input type="checkbox"/> was evaluated for risk factors for opioid-related harm <input type="checkbox"/> if identified to be at high risk for opioid-related harm, the prescriber considered prescribing naloxone <input type="checkbox"/> has a recent UDS testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, tramadol, and carisoprodol). Date of last UDS: _____			
7. For requests for nasal butorphanol (Stadol), check all of the following that apply to the beneficiary. Submit documentation for EACH item. <input type="checkbox"/> the patient is opioid-tolerant (names and dosages of current opioid regimen) <input type="checkbox"/> if being treated for migraine, has a history of trial & failure of or contraindication or intolerance to abortive (triptans) & preventive medications			

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

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