OPIOIDS PRIOR AUTHORIZATION FORM

ONLY the prescriber may complete this form.

Patient Information				**Today's Date**
Patient First Name:	Patient Last Name:		MI.	DOB (mm/dd/yyyy):
Patient Street Address:	City:	State:	Zip:	Patient Phone:

Insurance Information	
Member ID Number:	Group Number:

Prescriber/Clinic Information			
Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:

Medical information. Please attach additional information as needed.	
Patient Diagnosis with ICD-9 Code:	ICD-10 Code:
Medication and Strength Requested:	
Dosing Schedule:	Quantity per Month:

ALL REQUESTS

Please list the medications the patient has previously tried and failed for the treatment of this diagnosis:

	Date:		Date:
	Date:		Date:
	Date:		Date:

Please list all reasons for selecting the requested **medication, dosing schedule and quantity** over alternatives (e.g.contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried.)	_____ _____ _____
Please list all other medications the patient will take in **combination** with the requested medication.	_____ _____ _____ _____

Is the patient currently treated with the requested medication?	☐ **YES** ☐ **NO**	**If yes:** When was treatment with the requested medication started?

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

For Opioid Extended Release (ER) Requests

The patient's medication history includes a trial of at least 7 days of an immediate-acting opioid.	☐ **YES** ☐ **NO**
Is the patient eligible for hospice care*? **Please provide medical record documentation.*	☐ **YES** ☐ **NO**
Does the patient have a diagnosis of chronic cancer pain due to an active malignancy? **Please provide medical record documentation.*	☐ **YES** ☐ **NO**
Is treatment for chronic non-cancer pain? **If yes: The following documentation must be provided for review:** **1)** Formal Consultative Evaluation including: • Diagnosis • A complete medical history which includes previous and current pharmacological and non-pharmacological therapy	☐ **YES** ☐ **NO**
The prescriber has confirmed that a patient-specific pain management plan is on file for the patient.	☐ **YES** ☐ **NO**
Has the prescriber confirmed that the patient is not diverting the requested medication, according to the state's prescription drug monitoring program (PDMP) if applicable?	☐ **YES** ☐ **NO**

For Opioid Immediate Release (IR) Requests

Is the patient opioid naive? (Note: Naive is defined as 7 days or greater without being on an opioid and not taking an opioid every day in the previous 60 days. Patients that received opioids in a hospital are considered opioid naive.)	☐ **YES** ☐ **NO**
Is the patient eligible for hospice care*? **Please provide medical record documentation.*	☐ **YES** ☐ **NO**
Does the patient have a diagnosis of chronic cancer pain due to an active malignancy? **Please provide medical record documentation.*	☐ **YES** ☐ **NO**
Is treatment for chronic non-cancer pain? **If yes: The following documentation must be provided for review:** **1)** Formal Consultative Evaluation including: • Diagnosis • A complete medical history which includes previous and current pharmacological and non-pharmacological therapy	☐ **YES** ☐ **NO**
The prescriber has confirmed that a patient-specific pain management plan is on file for the patient.	☐ **YES** ☐ **NO**
Has the prescriber confirmed that the patient is not diverting the requested medication, according to the state's prescription drug monitoring program (PDMP) if applicable?	☐ **YES** ☐ **NO**

Physician's Signature:

Date Signed _____

Please fax or mail fax the signed and completed form to:

Pharmacy Review
Post Office Box 529
Auburn, AL 36381

TOLL FREE - Fax: 1-866-606-6021