PRIOR AUTHORIZATION REQUEST

Short Acting Opioids

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 2) [] Continuation (If checked, go to 5)		
2	Is the request for one of the preferred single-agent or combination short-acting opioid products? [If yes, skip to question 6.] [Note: Preferred agents include Morphine IR, Oxycodone IR, Hydromorphone IR,	Yes	No

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	Tramadol IR, Hydrocodone/APAP, Oxycodone/APAP, Hydrocodone/IBU, APAP/Codeine, Tramadol/APAP]		
3	Has the patient tried at least THREE of the preferred formulary alternatives for at least 3 months in the last 365 days? [If yes, skip to question 6.]	Yes	No
4	Is the patient intolerant to or contraindicated to at least THREE preferred alternatives? ACTION REQUIRED: Submit supporting documentation. [NOTE: Must have clinical documentation of intolerance to or contraindication to at least THREE preferred alternatives.] [If yes, skip to question 6.] [If no, no further questions.]	Yes	No
5	Is the patient responding to treatment? [If no, no further questions.]	Yes	No
6	Is the patient currently an inpatient at an acute care hospital?	Yes	No
7	Is the patient being discharged from the hospital or emergency department?	Yes	No
8	Is the patient pregnant?	Yes	No
9	Is the patient undergoing active cancer treatment? If yes, please document the type of cancer _____. [If yes, no further questions.]	Yes	No
10	Does the patient have sickle cell disease? [If yes, no further questions.]	Yes	No
11	Is the patient being treated as part of hospice care, long term care, skilled nursing facility care, or palliative care (diagnosis code Z51.5)? If yes, please document the diagnosis _____. [If yes, no further questions.]	Yes	No
12	Are you an inpatient hospital, ambulatory surgery center, or emergency room prescriber, OR are you an outpatient prescriber providing ongoing care? [] Inpatient hospital, ambulatory surgery, or emergency room prescriber (If checked, go to 13) [] Outpatient prescriber providing ongoing care (If checked, go to 17) [] None of the above. Please document prescriber's specialty and setting _____ (If checked, go to 17)		
13	Have you discussed the risks/benefits associated with opioid use with patient or	Yes	No

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	the patient's household?		
14	Is the patient exempt from need for a Patient-Prescriber Pain Management/Opioid Treatment Agreement and random urine drug screen (UDS) because he/she is being discharged from the Hospital/Ambulatory surgery center (ASC)/Emergency room (ER) and opioid treatment prescribed by the discharging provider will be for less than 30 days or the need for further opioid use will be re-evaluated by an outpatient provider within 30 days?	Yes	No
15	Has a Naloxone prescription been provided or offered to the patient or the patient's household?	Yes	No
16	Have you reviewed the Controlled Substance Prescriptions in Prescription Drug Monitoring Program (PDMP) (Chesapeake Regional Information System for our Patients [CRISP])? [If yes, skip to question 22.] [If no, no further questions.]	Yes	No
17	Will the patient have random Urine Drug Screens?	Yes	No
18	Is the Patient/Prescriber Pain Management/Opioid Treatment Agreement signed and in medical record?	Yes	No
19	Have you discussed the risks/benefits associated with opioid use with patient or the patient's household?	Yes	No
20	Has a Naloxone prescription been provided or offered to the patient or the patient's household?	Yes	No
21	Have you reviewed the Controlled Substance Prescriptions in Prescription Drug Monitoring Program (PDMP) (Chesapeake Regional Information System for our Patients [CRISP])? [If no, no further questions.]	Yes	No
22	Has the patient’s diagnosis been submitted? Please document the diagnosis _____. [If no, no further questions.]	Yes	No
23	Does the requested quantity exceed the quantity limits placed on this medication? Please document the requested quantity for the medication _____. [If no, no further questions.]	Yes	No
24	Has the provider evaluated the need for the requested quantity and assessed opportunities to wean opioid utilization when appropriate? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250