Medication Prior Authorization Form
Fax to 1-866-240-8123

Opioids

Member Information:

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

Provider Information:

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

Medication Information:

Drug Name	Drug strength	Requested Quantity	Requested Day Supply ☐ 30 days ☐ 90 days ☐ Other: _____
Directions			
Diagnosis and/or ICD-10 code(s)			

Clinical Information:

1. Please check **ALL** that apply:

☐ The member has chronic pain
☐ The member has pain associated with cancer (please provide cancer diagnosis): _____
☐ The member has pain associated with end-of-life care or palliative care
☐ The member has pain associated with sickle cell anemia
☐ The member resides in a long-term care facility
☐ The member has a documented acute pain condition (e.g., acute traumatic injury) in which treatment with other agents would cause insufficient pain control
☐ The member requires treatment for pain related to a terminal illness
☐ None of the above

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

☐ The member has pain severe enough to require daily, around-the-clock, long-term opioid treatment
☐ The member 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 member's history of controlled substance prescriptions has been checked using the state prescription drug monitoring program (PDMP)
☐ The member 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 member's clinical circumstances, is the prescribed amount of opioid warranted in order to adequately manage the member'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. Is the member currently enrolled in hospice?	Yes	No
If **YES**, please answer the following questions:		
5a. Is this medication being used to treat the member's terminal/hospice diagnosis?	Yes	No
5b. Is this medication being used to treat a condition related to the member's terminal/hospice diagnosis (e.g., pain, nausea, constipation, anxiety, etc.)?	Yes	No

Medication History:

Please provide any other medications that the member has tried and failed:

_____

_____

_____

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 member. 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. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. 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