



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

**SHORT-ACTING OPIOID PRIOR AUTHORIZATION FORM**

**PATIENT INFORMATION**

Subscriber ID Number		Group Number	
Patient Name	Patient Telephone Number	Date of Birth	
Patient Address	City	State	Zip Code

**MEDICATION INFORMATION**

Drug Name	Strength	Requested Quantity <u>per Month</u>
Diagnosis		

**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
- Post-operative procedure care
- None of the above

2. Is the patient currently utilizing opioid therapy on a consistent basis for chronic pain (defined as prescribed opioids for use for 90 out of the past 110 days)?

Yes

No

3. Please check ALL that apply. The patient has severe pain and

- Non-opioid therapies (e.g. nonsteroidal anti-inflammatory drugs [NSAIDs], acetaminophen) have provided an inadequate response or are inappropriate according to the prescriber
- 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

4. 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

**MEDICAL RATIONALE / REASON FOR DRUG THERAPY**

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**PRESCRIBER INFORMATION**

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

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.