Opioid Use Prior Authorization Form

For assistance, please call 1-855-552-6028 or fax completed form to 570-271-5610.

Medical documentation may be requested. This form will be returned if not completed in full.

Patient Information		***Prescriber Information***		
Patient Name:		*Prescriber Name:*		
Member ID#:		*NPI# (if available):*		
Address:		*Address:*		
City:	*State:*	*City:*		*State:*
Home Phone:	*Zip:*	*Office Phone #:*	*Office Fax #:*	*Zip:*
Sex (circle): M F	DOB:	*Contact Person:*		

Medication Information		
Medication:	*Strength:*	*Dose/Frequency*
Date Therapy Initiated:	*Diagnosis:*	

Rationale/Supporting Documentation for Prior Authorization Request

Please check all that apply:

□ Member has diagnosis of active cancer or receiving palliative care
□ Member has diagnosis of Sickle cell disease
□ Member is receiving hospice care
□ Provider has queried the state's Prescription Drug Monitoring Program (PDMP) to ensure controlled substance history is consistent with prescribing record for each controlled substance prescription written
Has the prescriber assessed the patient's pain, cause of pain, and documented the anticipated duration of therapy? □ Yes □ No
□ Is there medical record documentation of therapeutic failure on, intolerance to, or contraindication to first line drug and non-drug treatments for pain? □ Yes □ No
□ **One** of the following applies:

1. Medication is being prescribed based on recommendation of pain specialist and/or member has been or will be evaluated by a pain specialist for the same condition within previous 24 months
   Date of evaluation by pain specialist: _____
   Name of pain specialist: _____ **OR**
2. Does the member have signed pain contract or controlled substance contract in place with office? □ Yes □ No **OR**
3. Member requires more than a 3 day supply (minors) or 5 day supply (adult) of opioids to stabilize an acute medical condition or is tapering off opioids
   Duration of treatment/taper: _____

□ Member will receive a prescription for naloxone if dose of opioid is 120 MEDs (50 MEDs for minors) or greater and member is not being treated for end of life or the prescriber determines the member is at risk for overdose at any MED

□ Prescriber has provided counseling to the patient and parent/guardian/authorized adult, if applicable, regarding the potential risks and benefits of opioid use, including the possible increased risk in patients with a remote history or a strong family history of addiction
□ Member has been screened using CAGE-AID, Opioid Risk Tool or other tool for risk of opioid use disorder
Has a urine drug screening, including the prescribed opioid, per CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 guidelines been done? □ Yes □ No
Is there a plan for tapering off benzodiazepines or rationale for continued use (if applicable) □ Yes □ No □ N/A

For Long Acting Opioids:

Is there medical record documentation of therapeutic failure on, intolerance to, or contraindication to a short-acting opioid? □ Yes □ No

For Minors:

Have you obtained written consent for the prescription from the minor's parent/guardian/authorized adult on a standardized consent form and has recipient or parent/guardian has been educated on the potential adverse effects of opioid analgesics? □ Yes □ No

I attest that the above information is accurate to the best of my knowledge and have submitted supporting documentation.

Prescriber's Signature: