Geisinger
GHP Family

Opioid cumulative morphine equivalent dose (MED) or opioid use in minors prior authorization form

For assistance, call 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	Date of birth:	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 a diagnosis of active cancer or receiving palliative care.
- □ Member has a diagnosis of sickle cell disease.
- □ Member is receiving hospice care.
- □ Provider has queried the state's Prescription Drug Monitoring Program (PDMP) to ensure the controlled substance history is consistent with the prescribing record for each controlled substance prescription written.
- □ Medication is being prescribed based on recommendation of a pain specialist and/or member has been or will be evaluated by a pain specialist
  - Date of evaluation by pain specialist: _____
  - Name of pain specialist: _____
- □ 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 or other tool for risk of opioid use disorder.

Has a urine drug screening per ASAM guidelines been done? □ Yes □ No
Is there a plan for tapering off benzodiazepines or rationale for continued use (if applicable) □ Yes □ No
Is the member a candidate for a non-opioid alternative? □ Yes □ No
Does the member require more than a 7-day supply of opioids (minors) or 14-day supply (adults) to stabilize an acute medical condition or taper off opioids? □ Yes □ No Duration of treatment_____

For Doses Exceeding 50 MEDs:

Does the member have a signed pain contract or controlled substance contract in place with office? □ 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: