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

SHORT-ACTING OPIOID PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

Subscriber's ID Number	Subscriber's Group Number

Patient's Name	Phone	Date of Birth

Address	City	State	Zip Code

PRESCRIBER INFORMATION

Physician's Name	NPI	Phone	Fax

Address	City	State	Zip Code

Suite / Building	Physician's Signature	Date

MEDICATION INFORMATION

Diagnosis:

Quantity:	Day Supply:

CLINICAL CRITERIA

1. Please check **ALL** that apply. The patient has pain associated with:

☐ Cancer (please provide diagnosis): _____

☐ Hospice, 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 (currently receiving opioids on a consistent basis is defined as prescribed 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, tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors [SNRIs], anticonvulsants) have provided 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
5. 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

6. Please provide any other medications previously tried and failed for the patient's diagnosis:

_____

_____

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.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. 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