HIGHMARK | HIGHMARK

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 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

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:

- Exercise therapy, Physical therapy, Weight loss, Cognitive behavioral therapy

☐ Non-opioid therapies have provided an inadequate response or are inappropriate

☐ Use of an NSAID (nonsteroidal anti-inflammatory drug) would be inappropriate

☐ 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 utilizing opioid therapy on a consistent basis for chronic pain (defined as prescribed use for 90 out of the past 110 days)?	Yes	No
6. Does the member have pain associated with active cancer treatment or cancer not in remission?	Yes	No
If **YES:**		
6a. Please provide cancer diagnosis: _____		
7. Is the member a cancer survivor being treated for chronic pain?	Yes	No
If **YES**:		
7a. Has the member completed cancer treatment?	Yes	No
7b. Is the member in clinical remission?	Yes	No
7c. Is the member under cancer surveillance only?	Yes	No
8. Is the member currently enrolled in hospice?	Yes	No
If **YES**:		
8a. Is this medication being used to treat the member's terminal/hospice diagnosis?	Yes	No
8b. 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, SPECARE, Pittsburgh, PA 15222

The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life, Highmark Care Benefits Inc., or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.