FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Kadian® (morphine extended-release [ER] capsule)
Long-Acting Opioid Prior Authorization Request Form (Page 1 of 3)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

For states, such as GA and AR, that have a terminal illness mandate, and for patients who have a terminal illness, please answer the following:

Will the requested medication be used for the treatment of a terminal condition or associated symptoms? ❑ **Yes** ❑ **No**

If "YES", please indicate the patient's estimated life expectancy:

❑ Less than 6 months ❑ Less than 24 months ❑ Less than ____ months (please specify)

Continuation of therapy:

Is the patient established on the prescribed medication and this prescription is for continuation of therapy? ❑ **Yes** ❑ **No**

Select all the applicable diagnoses below:

❑ Cancer pain
❑ Moderate to severe chronic pain that is non-neuropathic
❑ Moderate to severe neuropathic pain or fibromyalgia
❑ Other diagnosis: _____ ❑ ICD-10 Code(s):_____

End of life care:

Is the patient receiving opioids as part of end of life care? ❑ **Yes** ❑ **No**

For diagnosis of moderate to severe chronic pain that is non-neuropathic, please answer the following:

Is the prescribed medication being used as an as-needed (PRN) analgesic? ❑ **Yes** ❑ **No**

Is the prescribed medication being used for pain that is mild or not expected to persist for an extended period of time? ❑ **Yes** ❑ **No**

Is the prescribed medication being used for acute pain? ❑ **Yes** ❑ **No**

Is the prescribed medication being used for postoperative pain? ❑ **Yes** ❑ **No** If **yes**, please answer the following:

- Has the patient already received chronic opioid therapy prior to surgery or is the postoperative pain expected to be moderate to severe and persist for an extended period of time? ❑ **Yes** ❑ **No**

Is the patient filling the prescribed medication for the first time? ❑ **Yes** ❑ **No**

Prior to the start of therapy with the prescribed medication, has the patient failed an adequate trial of a short-acting opioid? ❑ **Yes** ❑ **No**

If **yes**, please document the name of the medication(s), dose, date, and duration of trial:

Medication: _____ Dose: _____ Date of trial: _____ Duration of trial: _____

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For diagnosis of moderate to severe neuropathic pain or fibromyalgia, please answer the following:

Does the patient have a contraindication to or has not exhibited an adequate response to treatment with gabapentin titrated to a therapeutic dose? ❑ **Yes** ❑ **No** If **yes**, please document dose, date, and duration of trial:
Dose: _____ Date of trial: _____ Duration of trial: _____

Does the patient have a contraindication to or has not exhibited an adequate response to treatment with a tricyclic antidepressant titrated to a therapeutic dose? ❑ **Yes** ❑ **No** If **yes**, please document the name of the medication(s), dose, date, and duration of trial:
Medication: _____ Dose: _____ Date of trial: _____ Duration of trial: _____

Is the patient filling the prescribed medication for the first time? ❑ **Yes** ❑ **No**

Prior to the start of therapy with the prescribed medication, has the patient failed an adequate trial of a short-acting opioid? ❑ **Yes** ❑ **No**

If **yes**, please document the name of the medication(s), dose, date, and duration of trial:
Medication: _____ Dose: _____ Date of trial: _____ Duration of trial: _____

Select the medications the patient has a trial and failure, contraindication, or intolerance to:

- ❑ Embeda (morphine sulfate and naltrexone hydrochloride)
- ❑ Hydromorphone ER
- ❑ Hysingla ER
- ❑ Morphine sulfate ER
- ❑ Oxycontin (oxycodone hydrochloride)
- ❑ Oxymorphone ER

Reauthorization [Non-cancer and non-end of life care only]:
If this is a reauthorization request, please answer all of the following questions:

1. What are the treatment goals for this patient? (Document treatment goals and estimated duration of treatment) _____
   _____
2. Does the treatment plan include the use of a non-opioid analgesic and/or non-pharmacologic intervention? ❑ **Yes** ❑ **No**
3. Has the patient demonstrated meaningful improvement in pain and function using a validated instrument (e.g., Brief Pain Inventory)? ❑ **Yes** ❑ **No**
4. Has the patient been screened for substance abuse/opioid dependence using a validated instrument (e.g., DAST-10)? ❑ **Yes** ❑ **No**
5. What is the rationale for not tapering and discontinuing the requested medication? (Document rationale) _____
   _____
6. Has the patient been screened for comorbid mental health conditions? ❑ **Yes** ❑ **No**
7. Is there a state prescription drug monitoring program (PDMP) available? ❑ **Yes** ❑ **No**
   If **yes**, has the prescriber identified that there are NO concurrently prescribed controlled substances from the PDMP? ❑ **Yes** ❑ **No**
8. Does the prescriber acknowledge that he/she has completed an assessment of increased risk for respiratory depression in patients who have medical comorbidities or are using concurrent benzodiazepine/other drugs that could potentially cause drug-drug interactions? ❑ **Yes** ❑ **No**
9. What is the patient's total daily morphine equivalent dose? _____

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Quantity limit requests:

What is the quantity requested per DAY? _____

Does the patient's diagnosis include malignant (cancer) pain? ❑ **Yes** ❑ **No**

Was the requested medication prescribed by a pain specialist or by pain management consultation? ❑ **Yes** ❑ **No**

Select all of the following that have been maintained and documented in chart notes*:

- ❑ A description of the nature and intensity of the pain
- ❑ An appropriate patient medical history and physical examination
- ❑ An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
- ❑ Appropriate dose escalation
- ❑ Ongoing, periodic review of the course of opioid therapy
- ❑ Verification that the risks and benefits of the use of the requested medication have been discussed with the patient, significant other(s), and/or guardian

***Chart documentation:**

Will chart documentation be submitted with this form, confirming the above information? ❑ **Yes** ❑ **No**

***Please note: Chart documentation of the above is required to be submitted along with this fax form.*

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.