



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

Opana ER® Long-Acting Opioid Prior Authorization Request Form (Page 1 of 3)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information <small>(required)</small>					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES", please indicate the patient's estimated life expectancy: <input type="checkbox"/> Less than 6 months <input type="checkbox"/> Less than 24 months <input type="checkbox"/> Less than ____ months (please specify)					
Continuation of therapy: Is the patient established on the prescribed medication and this prescription is for continuation of therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Please answer the following: Is the prescriber aware that Opana ER is being withdrawn from the market due to concerns of significant abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No Select all the applicable diagnoses below: <input type="checkbox"/> Moderate to severe chronic pain that is non-neuropathic <input type="checkbox"/> Moderate to severe neuropathic pain or fibromyalgia <input type="checkbox"/> Other diagnosis: _____ <input type="checkbox"/> ICD-10 Code(s): _____					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescribed medication being used for pain that is mild or not expected to persist for an extended period of time? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescribed medication being used for acute pain? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescribed medication being used for postoperative pain? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer the following: <ul style="list-style-type: none"> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the patient filling the prescribed medication for the first time? <input type="checkbox"/> Yes <input type="checkbox"/> No Prior to the start of therapy with the prescribed medication, has the patient failed an adequate trial of a short-acting opioid? <input type="checkbox"/> Yes <input type="checkbox"/> 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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 Office use only: OpanaER_FSP_2018Nov-W



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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
- Hydromorphone extended-release (ER)
- Hysingla ER
- Morphine sulfate ER
- Oxycontin
- Oxymorphone ER

Reauthorization:

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.