FUTURE SCRIPTS

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

Short-Acting Opioids Prior Authorization Request Form

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 ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Cancer

❑ Postoperative pain

❑ Other diagnosis: _____ ICD-10 Code(s): _____

End of life care:

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

Postoperative pain:

Is the requested medication being prescribed for pain related to a dental procedure? ❑ **Yes** ❑ **No**

Is the requested dose prescribed the same dose that the patient was stable on prior to discharge? ❑ **Yes** ❑ **No**

Other diagnoses:

Does the prescriber certify that there is an active treatment plan that includes but is not limited to a specific treatment objective and the use of other pharmacological and non-pharmacological agents for pain relief as appropriate? ❑ **Yes** ❑ **No**

Does the prescriber certify that there has been an informed consent document signed and an addiction risk assessment has been performed? ❑ **Yes** ❑ **No**

If **No**, has the prescriber (or prescriber's representative) verbally addressed the above with the patient? ❑ **Yes** ❑ **No**

Does the prescriber certify that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists? ❑ **Yes** ❑ **No**

If **No**, has the prescriber (or prescriber's representative) verbally addressed the above with the patient? ❑ **Yes** ❑ **No**

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.