FUTURE SCRIPTS

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

Short-acting Opioids for Continuation beyond 30 days
Prior Authorization Request Form

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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)

Select the diagnosis below:

❑ Pain associated with active cancer treatment or cancer not in remission

❑ Severe, persistent chronic non-cancer pain

- Document the diagnosis associated with the pain: _____

❑ Sickle cell anemia

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

Clinical information:

Is there documentation of a current patient-prescriber opioid treatment agreement (signed within 1 year of request)? ❑ **Yes** ❑ **No**

Was the requested medication regimen prescribed by or in consultation with a pain management specialist within the last 6 months? ❑ **Yes** ❑ **No**

If **yes**, provide the name of the physician and date of last visit. Name:_____Date: _____

Select if the pain management specialist is board certified by one of the following below:

❑ American Board of Anesthesiology - Pain Management
❑ American Board of Psychiatry & Neurology - Pain Management
❑ American Board of Physical Medicine & Rehabilitation
❑ American Osteopathic Association - Pain Management

Select if the prescriber has evaluated the patient for the following therapies below:

❑ Physical therapy
❑ Psychotherapy
❑ Adjuvant medications specific to causative condition including but not limited to any of the following: Antidepressants, anticonvulsants, muscle relaxants, anti-inflammatory agents

Is there documentation that a urine drug screen (UDS) will be performed by the prescriber within 1 year of request? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per DAY? _____

Does the requested dose and frequency exceed FDA approved dosing? ❑ **Yes** ❑ **No**

Is the requested dose and frequency supported by compendia? ❑ **Yes** ❑ **No**

Is there documentation indicating medical necessity for a quantity that exceeds the plan limit (e.g., GI malabsorption) or the dose cannot be achieved with commercially available clinical dosage forms? ❑ **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.