



**Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.**

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at [www.mercycareaz.org/providers/pharmacy.html](http://www.mercycareaz.org/providers/pharmacy.html)

## Opioids – Long and Short Acting Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently

**REQUIRED: Office notes, labs, and medical testing relevant to request showing medical justification are required to support diagnosis**

| Member Information                                                                                                                                                |  |                                                                                                                                                                                                                           |                                                          |                                 |                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|---------------------------------|--------------------------------------|
| Member Name (first & last):                                                                                                                                       |  | Date of Birth:                                                                                                                                                                                                            | Gender:                                                  |                                 | Height:                              |
|                                                                                                                                                                   |  |                                                                                                                                                                                                                           | <input type="checkbox"/> Male                            | <input type="checkbox"/> Female |                                      |
| Member ID:                                                                                                                                                        |  | City:                                                                                                                                                                                                                     | State:                                                   |                                 | Weight:                              |
| Prescribing Provider Information                                                                                                                                  |  |                                                                                                                                                                                                                           |                                                          |                                 |                                      |
| Provider Name (first & last):                                                                                                                                     |  | Specialty:                                                                                                                                                                                                                | NPI#                                                     |                                 | DEA#                                 |
| Office Address:                                                                                                                                                   |  | City:                                                                                                                                                                                                                     | State:                                                   |                                 | Zip Code:                            |
| Office Contact:                                                                                                                                                   |  | Office Phone                                                                                                                                                                                                              |                                                          | Office Fax:                     |                                      |
| Dispensing Pharmacy Information                                                                                                                                   |  |                                                                                                                                                                                                                           |                                                          |                                 |                                      |
| Pharmacy Name:                                                                                                                                                    |  | Pharmacy Phone:                                                                                                                                                                                                           |                                                          | Pharmacy Fax:                   |                                      |
| Requested Medication Information                                                                                                                                  |  |                                                                                                                                                                                                                           |                                                          |                                 |                                      |
| Long-Acting Opioid:                                                                                                                                               |  | Specify drug:                                                                                                                                                                                                             |                                                          |                                 |                                      |
| Short Acting Opioid:                                                                                                                                              |  | Specify drug:                                                                                                                                                                                                             |                                                          |                                 |                                      |
| Are there any contraindications to formulary medications?                                                                                                         |  |                                                                                                                                                                                                                           | <input type="checkbox"/> Yes                             | <input type="checkbox"/> No     | <input type="checkbox"/> New request |
| If yes, please specify:                                                                                                                                           |  |                                                                                                                                                                                                                           | <input type="checkbox"/> Continuation of therapy request |                                 |                                      |
| Directions for Use:                                                                                                                                               |  | Strength:                                                                                                                                                                                                                 |                                                          | Dosage Form:                    |                                      |
|                                                                                                                                                                   |  | Quantity:                                                                                                                                                                                                                 | Day Supply:                                              | Duration of Therapy/Use:        |                                      |
| Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one):    Yes    No                                                       |  |                                                                                                                                                                                                                           | Diagnosis:                                               |                                 | ICD-10 Code:                         |
| What medication(s) has member tried and failed for this diagnosis? Please specify:                                                                                |  |                                                                                                                                                                                                                           |                                                          |                                 |                                      |
| Turn-Around Time for Review                                                                                                                                       |  |                                                                                                                                                                                                                           |                                                          |                                 |                                      |
| <input type="checkbox"/> Standard – (24 hours)                                                                                                                    |  | <input type="checkbox"/> <b>Urgent</b> – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.<br>Signature: _____ |                                                          |                                 |                                      |
| Clinical Information                                                                                                                                              |  |                                                                                                                                                                                                                           |                                                          |                                 |                                      |
| LONG-ACTING OPIOIDS                                                                                                                                               |  |                                                                                                                                                                                                                           |                                                          |                                 |                                      |
| <input type="checkbox"/> <b>For use of MAT and other Opioids</b>                                                                                                  |  |                                                                                                                                                                                                                           |                                                          |                                 |                                      |
| For Medication Assisted Treatment therapy, will the provider notify the prescriber of the MAT therapy, AND the prescriber approves the concurrent opioid therapy? |  |                                                                                                                                                                                                                           |                                                          | <input type="checkbox"/> Yes    | <input type="checkbox"/> No          |
| For a surgical procedure, will the day supply exceed 14 days for a surgical procedure?                                                                            |  |                                                                                                                                                                                                                           |                                                          | <input type="checkbox"/> Yes    | <input type="checkbox"/> No          |
| For all other requests besides surgical procedure, does the day supply exceed 5 days?                                                                             |  |                                                                                                                                                                                                                           |                                                          | <input type="checkbox"/> Yes    | <input type="checkbox"/> No          |
| Has the member had a previous approval in the last 6 months?                                                                                                      |  |                                                                                                                                                                                                                           |                                                          | <input type="checkbox"/> Yes    | <input type="checkbox"/> No          |
| <input type="checkbox"/> Cancer Related Pain / Hospice Care / End-of-Life Care                                                                                    |  |                                                                                                                                                                                                                           |                                                          |                                 |                                      |
| Is the member being treated for cancer OR receiving hospice OR end-of-life care?                                                                                  |  |                                                                                                                                                                                                                           |                                                          | <input type="checkbox"/> Yes    | <input type="checkbox"/> No          |
| The member has a history of failure, C/I, or intolerance to a trial of at least THREE of the following:                                                           |  | <input type="checkbox"/> Morphine sulfate-controlled release tablets (generic MS Contin)                                                                                                                                  |                                                          |                                 |                                      |
|                                                                                                                                                                   |  | <input type="checkbox"/> Preferred fentanyl transdermal 72-HOUR 12mcg, 25mcg, 50mcg, 75mcg & 100mcg                                                                                                                       |                                                          |                                 |                                      |
|                                                                                                                                                                   |  | <input type="checkbox"/> Brand Butrans (buprenorphine) transdermal                                                                                                                                                        |                                                          |                                 |                                      |
|                                                                                                                                                                   |  | <input type="checkbox"/> Brand Oxycontin                                                                                                                                                                                  |                                                          |                                 |                                      |
|                                                                                                                                                                   |  | <input type="checkbox"/> Tramadol ER tablets (non-biphasic release tablets)                                                                                                                                               |                                                          |                                 |                                      |
|                                                                                                                                                                   |  | <input type="checkbox"/> Generic methadone tablets/concentrate/soln/tablets for oral susp                                                                                                                                 |                                                          |                                 |                                      |

|                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               |                                          |                                                                                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------------------------------------------------------------------|
| There was a HX of failure, C/I, or intolerance to BOTH of the following:<br>Document date of trial: _____                                                                                                                                                                            |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             | <input type="checkbox"/> tramadol ER tablets (non-biphasic release tablets)                                                                                                                                              |                                                                                                               | <input type="checkbox"/> tramadol IR     |                                                                                      |
| Is the member ESTABLISHED on pain therapy with the requested medication AND the medication is NOT a new regimen?                                                                                                                                                                     |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| <input type="checkbox"/> <b>Doses Exceeding Cumulative MME of 90mg</b><br><b>Cancer / Hospice / End-of-Life / Palliative Care / Skilled Nursing Facility / Traumatic Injury Related Pain</b>                                                                                         |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               |                                          |                                                                                      |
| Member has ONE of the following conditions:                                                                                                                                                                                                                                          | <input type="checkbox"/> Active oncology diagnosis                                                                                                                                                                                                                   |                              | <input type="checkbox"/> Hospice care                                                                                                                                       |                                                                                                                                                                                                                          | <input type="checkbox"/> End-of-life care                                                                     |                                          |                                                                                      |
|                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Palliative care                                                                                                                                                                                                                             |                              | <input type="checkbox"/> Skilled nursing facility care                                                                                                                      |                                                                                                                                                                                                                          | <input type="checkbox"/> Traumatic injury, including burns & excluding post-surgical procedure                |                                          |                                                                                      |
| Does the prescriber attest that the member has been prescribed naloxone? (may also be verified via paid pharmacy claims)                                                                                                                                                             |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| <input type="checkbox"/> <b>Non-Cancer Pain / Non-Hospice Care / Non-End-of-Life Care Pain</b>                                                                                                                                                                                       |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               |                                          |                                                                                      |
| Are the treatment goals defined, including estimated duration of treatment?                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| Does the treatment plan include the use of a non-opioid analgesic AND/OR a non-pharmacologic intervention?                                                                                                                                                                           |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| Has the member been screened for substance abuse/opioid dependence?                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| If used in members with medical comorbidities OR if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, has the prescriber acknowledged that they have completed an assessment of increased risk for respiratory depression? |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| Is the pain moderate to severe AND expected to persist for an extended period of time?                                                                                                                                                                                               |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| Is the pain chronic?                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Yes                                                                                                                                                                                                                                         | <input type="checkbox"/> No  | Is pain management required around the clock with a long-acting opioid?                                                                                                     |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| Is the Pain NOT postoperative?<br>(Unless member is already receiving chronic opioid therapy prior to surgery, OR if the postoperative pain is expected to be moderate to severe AND persist for an extended period of time)                                                         |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| Prior to start of therapy, was there a failure with an adequate (MIN of 2 weeks) trial of a short-acting opioid within the last 30 days? Document drug(s) and date of trial: _____                                                                                                   |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| Is the request for neuropathic pain?                                                                                                                                                                                                                                                 | <input type="checkbox"/> Yes                                                                                                                                                                                                                                         | <input type="checkbox"/> No  | Was there an adequate response to 8 weeks of TX with gabapentin AND a tricyclic antidepressant titrated to a MAX therapeutic dose?<br>If yes, document date of trial: _____ |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
|                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                      |                              | Is there a C/I to gabapentin or to the tricyclic antidepressant?                                                                                                            |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| <input type="checkbox"/> <b>Dosing Exceeding Cumulative MME of 90mg</b><br><b>Non-cancer / Non-Hospice / Non-End-of-Life / Non-Palliative Care / Non-Skilled Nursing Facility / Traumatic Injury Related Pain</b>                                                                    |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               |                                          |                                                                                      |
| Prescriber attests to ALL the following:                                                                                                                                                                                                                                             | <input type="checkbox"/> INFO provided is true & accurate to best of provider knowledge                                                                                                                                                                              |                              | <input type="checkbox"/> TX goals are defined, including estimated duration of TX                                                                                           |                                                                                                                                                                                                                          | <input type="checkbox"/> TX plan includes use of a non-opioid analgesic and/or non-pharmacologic intervention |                                          | <input type="checkbox"/> MBR has been screened for substance abuse/opioid dependence |
|                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> If used in MBRS with medical comorbidities OR if used concurrently with a BNZ OR other drugs that could potentially cause DDI, the provider has acknowledged they have completed an assessment of increased risk for respiratory depression |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               |                                          |                                                                                      |
| Has the member T/F NON-OPIOID pain medication?                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| Drug Name: _____ Date of Trial: _____                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| Does the prescriber attest that the member has been prescribed naloxone? (may also be verified via paid pharmacy claims)                                                                                                                                                             |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| <input type="checkbox"/> <b>Criteria for Quantity Limit Reviews</b>                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               |                                          |                                                                                      |
| Can the requested dose be achieved by moving to a higher strength of the product?                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| Is the requested dose within the FDA MAX dose per day, where an FDA MAX dose per day exists?                                                                                                                                                                                         |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| <input type="checkbox"/> <b>Opioid Naïve (Not having filled an opioid in the past 120 days)</b>                                                                                                                                                                                      |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               |                                          |                                                                                      |
| Is the request for 50 MME to 90 MME?                                                                                                                                                                                                                                                 | <input type="checkbox"/> Yes                                                                                                                                                                                                                                         | <input type="checkbox"/> No  | Diagnosis for ONE of the following:                                                                                                                                         | <input type="checkbox"/> Cancer                                                                                                                                                                                          | <input type="checkbox"/> End of life pain (including hospice)                                                 | <input type="checkbox"/> Palliative care | <input type="checkbox"/> Sickle cell anemia                                          |
| Is the member currently exceeding 50 MME AND prescriber attests that member has been on short-acting opioid in the past 120 days?                                                                                                                                                    |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| Is the diagnosis associated with the need for pain management with an opioid?                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No                                                                                                                                                 | If used for medical comorbidities OR concurrently with a BNZ or other drugs that could cause DDI's, has the prescriber acknowledged that they have completed an assessment of increased risk for respiratory depression? |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| Has the prescriber acknowledged that they have completed an addiction risk AND a risk of overdose assessment?                                                                                                                                                                        |                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No                                                                                                                                                 | Can the prescriber attest that the member requires >50 MME/day to adequately control pain?                                                                                                                               |                                                                                                               | <input type="checkbox"/> Yes             | <input type="checkbox"/> No                                                          |
| <input type="checkbox"/> <b>Renewal Requests ONLY</b><br><b>Non-Cancer Pain / Non-Hospice Care / Non-End-of-Life Care Pain</b>                                                                                                                                                       |                                                                                                                                                                                                                                                                      |                              |                                                                                                                                                                             |                                                                                                                                                                                                                          |                                                                                                               |                                          |                                                                                      |

|                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     |                                                                                           |                                             |                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------------------|------------------------------|
| Does the member demonstrate a meaningful improvement in pain and function?<br>If yes, document improvement:                                                                                                                                                                          |                                                                                                                                                                                                                                                                | <input type="checkbox"/> Yes                      | <input type="checkbox"/> No                                             | Is there rationale for NOT tapering and discontinuing the opioid?<br>If yes, document rationale:               |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| Are the treatment goals defined, including estimated duration of treatment?                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| Does the treatment plan include the use of a non-opioid analgesic AND/OR a non-pharmacologic intervention?                                                                                                                                                                           |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| Has the member been screened for substance abuse/opioid dependence?                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| If used in members with medical comorbidities OR if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, has the prescriber acknowledged that they have completed an assessment of increased risk for respiratory depression? |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| Is the pain moderate to severe AND expected to persist for an extended period of time?                                                                                                                                                                                               |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| Is the pain chronic?                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Yes                                                                                                                                                                                                                                   | <input type="checkbox"/> No                       | Is pain management required around the clock with a long-acting opioid? |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| Is the Pain NOT postoperative?<br>(Unless member is already receiving chronic opioid therapy prior to surgery, OR if the postoperative pain is expected to be moderate to severe AND persist for an extended period of time)                                                         |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| Prior to start of therapy, was there failure with a MIN of 2 weeks, trial with a short-acting opioid within last 30 days?                                                                                                                                                            |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| Drug(s) _____                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     |                                                                                           |                                             |                              |
| Date of trial: _____                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     |                                                                                           |                                             |                              |
| <b>SHORT-ACTING OPIOIDS</b>                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     |                                                                                           |                                             |                              |
| <input type="checkbox"/> <b>For use of MAT and other Opioids</b>                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     |                                                                                           |                                             |                              |
| For Medication Assisted Treatment therapy, will the provider notify the prescriber of the MAT therapy, AND the prescriber of the MAT therapy approves the concurrent opioid therapy?                                                                                                 |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| For a surgical procedure, will the day supply exceed 14 days for a surgical procedure?                                                                                                                                                                                               |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| For all other requests besides surgical procedure, does the day supply exceed 5 days?                                                                                                                                                                                                |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| Has the member had a previous approval in the last 6 months?                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| <input type="checkbox"/> <b>Non-Preferred Reviews</b>                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     |                                                                                           |                                             |                              |
| HX of failure, C/I, or intolerance to at least FIVE PREFERRED short-acting opioids:                                                                                                                                                                                                  | <input type="checkbox"/> Hydromorphone tablets (Dilaudid)                                                                                                                                                                                                      | <input type="checkbox"/> hydrocodone-APAP (Norco) | <input type="checkbox"/> tramadol 50mg tablets                          | <input type="checkbox"/> tramadol-acetaminophen tablets                                                        |                                                                                     |                                                                                           |                                             |                              |
|                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> oxycodone IR                                                                                                                                                                                                                          | <input type="checkbox"/> morphine sulfate IR      | <input type="checkbox"/> oxycodone w/ APAP (Percocet)                   | <input type="checkbox"/> APAP w/ codeine                                                                       |                                                                                     |                                                                                           |                                             |                              |
| <input type="checkbox"/> <b>PA Required for &gt; 2 Short Acting Opioids</b>                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     |                                                                                           |                                             |                              |
| Is the requested medication being used for adjusting the dose?                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 | <input type="checkbox"/> N/A |
| Is the requested medication to be used in place of previously prescribed drug, and NOT in addition to it?                                                                                                                                                                            |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 | <input type="checkbox"/> N/A |
| Is the requested medication a dosage form to be used in place of previously prescribed medication dosage form, and NOT in addition to it?                                                                                                                                            |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 | <input type="checkbox"/> N/A |
| Does the physician attest they are aware of MULTIPLE short-acting opioids prescribed AND feel TX with all medications is medically necessary?                                                                                                                                        |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 | <input type="checkbox"/> N/A |
| <input type="checkbox"/> <b>Quantity Limit</b>                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     |                                                                                           |                                             |                              |
| Is the dose being requested due to dose cannot be achieved by moving to a higher strength of the product?                                                                                                                                                                            |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| Does the requested dose fall within FDA approved MAX dose per day, where an FDA MAX dose per day exists?                                                                                                                                                                             |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| <input type="checkbox"/> <b>Greater than 5-day Supply</b>                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     |                                                                                           |                                             |                              |
| Member has ONE of the following conditions OR care instances:                                                                                                                                                                                                                        | <input type="checkbox"/> Active oncology                                                                                                                                                                                                                       | <input type="checkbox"/> End-of-life care         | <input type="checkbox"/> Skilled nursing facility care                  |                                                                                                                | <input type="checkbox"/> Chronic conditions for which provider received PA approval |                                                                                           |                                             |                              |
|                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Hospice care                                                                                                                                                                                                                          | <input type="checkbox"/> Palliative care          | <input type="checkbox"/> Post-surgical procedures                       |                                                                                                                | <input type="checkbox"/> Traumatic injury, excluding post-surgical procedures       |                                                                                           |                                             |                              |
| <input type="checkbox"/> <b>Opioid Naïve (Not having filled an opioid in past 120 days)</b>                                                                                                                                                                                          |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     |                                                                                           |                                             |                              |
| Is the request for 50 MME to 90 MME?                                                                                                                                                                                                                                                 | <input type="checkbox"/> Yes                                                                                                                                                                                                                                   | <input type="checkbox"/> No                       | Diagnosis is for ONE of the following:                                  | <input type="checkbox"/> Cancer                                                                                | <input type="checkbox"/> End of life pain                                           | <input type="checkbox"/> Palliative care                                                  | <input type="checkbox"/> Sickle cell anemia |                              |
| Is MBR currently exceeding 50 MME AND prescriber attests MBR has been on short-acting opioid in past 120 days?                                                                                                                                                                       |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     | <input type="checkbox"/> Yes                                                              | <input type="checkbox"/> No                 |                              |
| <input type="checkbox"/> DX is associated with need for pain management with opioid                                                                                                                                                                                                  | <input type="checkbox"/> Used in MBR w/medical comorbidities OR used concurrently with BNZ or other drugs that could potentially cause DDI, AND the prescriber has acknowledged they have completed an assessment of increased risk for respiratory depression |                                                   |                                                                         | <input type="checkbox"/> Prescriber acknowledged completion of an addiction risk & risk of overdose assessment |                                                                                     | <input type="checkbox"/> Prescriber attests MBR requires > 50 MME per day to control pain |                                             |                              |
| <input type="checkbox"/> <b>Cancer / Hospice / End of Life / Palliative Care/Skilled Nursing Facility / Traumatic Injury Related Pain Exceeding 90 MME</b>                                                                                                                           |                                                                                                                                                                                                                                                                |                                                   |                                                                         |                                                                                                                |                                                                                     |                                                                                           |                                             |                              |
| <input type="checkbox"/> Active oncology                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                |                                                   | <input type="checkbox"/> Hospice                                        |                                                                                                                | <input type="checkbox"/> End-of-life care                                           |                                                                                           |                                             |                              |
| <input type="checkbox"/> Palliative care                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                |                                                   | <input type="checkbox"/> Skilled nursing facility                       |                                                                                                                | <input type="checkbox"/> Traumatic injury, including burns & excluding              |                                                                                           |                                             |                              |

|                                                                                                                                                                                                                                             |                                                                                                             |                                                                                                                                                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                             |                                                                                                             | post-surgical procedures                                                                                                                                                   |
| <input type="checkbox"/> <b>Non-cancer / Non-hospice / Non-End-of-life / Non-palliative care / Non-skilled nursing facility / Non-traumatic injury related pain Exceeding 90 MME</b>                                                        |                                                                                                             |                                                                                                                                                                            |
| <input type="checkbox"/> TX goals are defined, including estimated duration of treatment                                                                                                                                                    | <input type="checkbox"/> TX plan includes use of non-opioid analgesic AND/OR non-pharmacologic intervention | <input type="checkbox"/> MBR has been screened for substance abuse/opioid dependence                                                                                       |
| <input type="checkbox"/> Used in MBR w/medical comorbidities OR used concurrently w/BNZ OR other drugs that could cause DDI, AND the prescriber acknowledged they have completed an assessment of increased risk for respiratory depression |                                                                                                             | <input type="checkbox"/> INFO provided is true & accurate AND a routine audit and request of medical information may be necessary to verify the accuracy of INFO provided  |
| <input type="checkbox"/> MBR T/F a NON-opioid pain medication:<br><br>Drug: _____<br>Date of trial: _____                                                                                                                                   |                                                                                                             | <input type="checkbox"/> Opioid medication doses < 90 MME have been tried AND did not adequately control pain<br><br>Drug regimen or MME: _____<br>Dates of Therapy: _____ |
| <b>Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.</b>                                                                                                   |                                                                                                             |                                                                                                                                                                            |
|                                                                                                                                                                                                                                             |                                                                                                             |                                                                                                                                                                            |

|                                                                                                              |                    |
|--------------------------------------------------------------------------------------------------------------|--------------------|
| <b>Signature affirms that information given on this form is true and accurate and reflects office notes.</b> |                    |
| <b>Prescribing Provider's Signature:</b> _____                                                               | <b>Date:</b> _____ |

**Please note: Incomplete forms or forms without the chart notes will be returned**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.