Fax completed prior authorization request form to 855-247-3677 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

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: ☐ Male ☐ Female	Height:
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? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ 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	
☐ Standard – (24 hours)	☐ **Urgent** – 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. Signature: _____

Clinical Information		
LONG-ACTING OPIOIDS		
☐ **For use of MAT and other Opioids**		
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?	☐ Yes	☐ No
For a surgical procedure, will the day supply exceed 14 days for a surgical procedure?	☐ Yes	☐ No
For all other requests besides surgical procedure, does the day supply exceed 5 days?	☐ Yes	☐ No
Has the member had a previous approval in the last 6 months?	☐ Yes	☐ No
☐ **Cancer Related Pain / Hospice Care / End-of-Life Care**		
Is the member being treated for cancer OR receiving hospice OR end-of-life care?	☐ Yes	☐ No

The member has a history of failure, C/I, or intolerance to a trial of at least THREE of the following:	☐ Morphine sulfate-controlled release tablets (generic MS Contin)
	☐ Preferred fentanyl transdermal 72-HOUR 12mcg, 25mcg, 50mcg, 75mcg & 100mcg
	☐ Brand Butrans (buprenorphine) transdermal
	☐ Brand Oxycontin
	☐ Tramadol ER tablets (non-biphasic release tablets)
	☐ Generic methadone tablets/concentrate/soln/tablets for oral susp

There was a HX of failure, C/I, or intolerance to BOTH of the following: Document date of trial: _____	☐ tramadol ER tablets (non-biphasic release tablets)	☐ tramadol IR	
Is the member ESTABLISHED on pain therapy with the requested medication AND the medication is NOT a new regimen?		☐ Yes	☐ No
☐ **Doses Exceeding Cumulative MME of 90mg** **Cancer / Hospice / End-of-Life / Palliative Care / Skilled Nursing Facility / Traumatic Injury Related Pain**			
Member has ONE of the following conditions:	☐ Active oncology diagnosis	☐ Hospice care	☐ End-of-life care
	☐ Palliative care	☐ Skilled nursing facility care	☐ 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)		☐ Yes	☐ No
☐ **Non-Cancer Pain / Non-Hospice Care / Non-End-of-Life Care Pain**			
Are the treatment goals defined, including estimated duration of treatment?		☐ Yes	☐ No
Does the treatment plan include the use of a non-opioid analgesic AND/OR a non-pharmacologic intervention?		☐ Yes	☐ No
Has the member been screened for substance abuse/opioid dependence?		☐ Yes	☐ 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?		☐ Yes	☐ No
Is the pain moderate to severe AND expected to persist for an extended period of time?		☐ Yes	☐ No
Is the pain chronic? ☐ Yes ☐ No	Is pain management required around the clock with a long-acting opioid?	☐ Yes	☐ No
Is the Pain NOT postoperative? (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)		☐ Yes	☐ 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:_____		☐ Yes	☐ No
Is the request for neuropathic pain? ☐ Yes ☐ No	Was there an adequate response to 8 weeks of TX with gabapentin AND a tricyclic antidepressant titrated to a MAX therapeutic dose? If yes, document date of trial:_____	☐ Yes	☐ No
	Is there a C/I to gabapentin or to the tricyclic antidepressant?	☐ Yes	☐ No
☐ **Dosing Exceeding Cumulative MME of 90mg** **Non-cancer / Non-Hospice / Non-End-of-Life / Non-Palliative Care / Non-Skilled Nursing Facility / Traumatic Injury Related Pain**			
Prescriber attests to ALL the following:	☐ INFO provided is true & accurate to best of provider knowledge	☐ TX goals are defined, including estimated duration of TX	☐ TX plan includes use of a non-opioid analgesic and/or non-pharmacologic intervention
	☐ MBR has been screened for substance abuse/opioid dependence		
	☐ 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? Drug Name: _____ Date of Trial: _____		☐ Yes	☐ No
Does the prescriber attest that the member has been prescribed naloxone? (may also be verified via paid pharmacy claims)		☐ Yes	☐ No
☐ **Criteria for Quantity Limit Reviews**			
Can the requested dose be achieved by moving to a higher strength of the product?		☐ Yes	☐ No
Is the requested dose within the FDA MAX dose per day, where an FDA MAX dose per day exists?		☐ Yes	☐ No
☐ **Opioid Naïve (Not having filled an opioid in the past 120 days)**			
Is the request for 50 MME to 90 MME? ☐ Yes ☐ No	Diagnosis for ONE of the following: ☐ Cancer ☐ End of life pain (including hospice) ☐ Palliative care ☐ 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?		☐ Yes	☐ No
Is the diagnosis associated with the need for pain management with an opioid? ☐ Yes ☐ 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?	☐ Yes	☐ No
Has the prescriber acknowledged that they have completed an addiction risk AND a risk of overdose assessment? ☐ Yes ☐ No	Can the prescriber attest that the member requires >50 MME/day to adequately control pain?	☐ Yes	☐ No
☐ **Renewal Requests ONLY** **Non-Cancer Pain / Non-Hospice Care / Non-End-of-Life Care Pain**			

Does the member demonstrate a meaningful improvement in pain and function? If yes, document improvement: _____	☐ Yes	☐ No	Is there rationale for NOT tapering and discontinuing the opioid? If yes, document rationale: _____	☐ Yes	☐ No
Are the treatment goals defined, including estimated duration of treatment?				☐ Yes	☐ No
Does the treatment plan include the use of a non-opioid analgesic AND/OR a non-pharmacologic intervention?				☐ Yes	☐ No
Has the member been screened for substance abuse/opioid dependence?				☐ Yes	☐ 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?				☐ Yes	☐ No
Is the pain moderate to severe AND expected to persist for an extended period of time?				☐ Yes	☐ No
Is the pain chronic?	☐ Yes	☐ No	Is pain management required around the clock with a long-acting opioid?	☐ Yes	☐ No
Is the Pain NOT postoperative? (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)				☐ Yes	☐ 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? Drug(s) _____ Date of trial:_____				☐ Yes	☐ No

SHORT-ACTING OPIOIDS

☐ **For use of MAT and other Opioids**

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?	☐ Yes	☐ No
For a surgical procedure, will the day supply exceed 14 days for a surgical procedure?	☐ Yes	☐ No
For all other requests besides surgical procedure, does the day supply exceed 5 days?	☐ Yes	☐ No
Has the member had a previous approval in the last 6 months?	☐ Yes	☐ No

☐ **Non-Preferred Reviews**

HX of failure, C/I, or intolerance to at least FIVE PREFERRED short-acting opioids:	☐ Hydromorphone tablets (Dilaudid)	☐ hydrocodone-APAP (Norco)	☐ tramadol 50mg tablets	☐ tramadol-acetaminophen tablets
	☐ oxycodone IR	☐ morphine sulfate IR	☐ oxycodone w/ APAP (Percocet)	☐ APAP w/ codeine

☐ **PA Required for > 2 Short Acting Opioids**

Is the requested medication being used for adjusting the dose?	☐ Yes	☐ No	☐ N/A
Is the requested medication to be used in place of previously prescribed drug, and NOT in addition to it?	☐ Yes	☐ No	☐ 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?	☐ Yes	☐ No	☐ N/A
Does the physician attest they are aware of MULTIPLE short-acting opioids prescribed AND feel TX with all medications is medically necessary?	☐ Yes	☐ No	☐ N/A

☐ **Quantity Limit**

Is the dose being requested due to dose cannot be achieved by moving to a higher strength of the product?	☐ Yes	☐ No
Does the requested dose fall within FDA approved MAX dose per day, where an FDA MAX dose per day exists?	☐ Yes	☐ No

☐ **Greater than 5-day Supply**

Member has ONE of the following conditions OR care instances:	☐ Active oncology	☐ End-of-life care	☐ Skilled nursing facility care	☐ Chronic conditions for which provider received PA approval
	☐ Hospice care	☐ Palliative care	☐ Post-surgical procedures	☐ Traumatic injury, excluding post-surgical procedures

☐ **Opioid Naïve (Not having filled an opioid in past 120 days)**

Is the request for 50 MME to 90 MME?	☐ Yes	☐ No	Diagnosis is for ONE of the following:	☐ Cancer	☐ End of life pain	☐ Palliative care	☐ Sickle cell anemia

Is MBR currently exceeding 50 MME AND prescriber attests MBR has been on short-acting opioid in past 120 days?	☐ Yes	☐ No	
☐ DX is associated with need for pain management with opioid	☐ 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	☐ Prescriber acknowledged completion of an addiction risk & risk of overdose assessment	☐ Prescriber attests MBR requires > 50 MME per day to control pain

☐ **Cancer / Hospice / End of Life / Palliative Care/Skilled Nursing Facility / Traumatic Injury Related Pain Exceeding 90 MME**

☐ Active oncology	☐ Hospice	☐ End-of-life care
☐ Palliative care	☐ Skilled nursing facility	☐ Traumatic injury, including burns & excluding

		post-surgical procedures
☐ **Non-cancer / Non-hospice / Non-End-of-life / Non-palliative care / Non-skilled nursing facility / Non-traumatic injury related pain Exceeding 90 MME**		
☐ TX goals are defined, including estimated duration of treatment	☐ TX plan includes use of non-opioid analgesic AND/OR non-pharmacologic intervention	☐ MBR has been screened for substance abuse/opioid dependence
☐ 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		☐ INFO provided is true & accurate AND a routine audit and request of medical information may be necessary to verify the accuracy of INFO provided
☐ MBR T/F a NON-opioid pain medication: Drug: _____ Date of trial: _____		☐ Opioid medication doses < 90 MME have been tried AND did not adequately control pain Drug regimen or MME: _____ Dates of Therapy: _____
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.		

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

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 800-564-5465 to check the status of a request.