PRIORITY partners

Opioid Prior Authorization Form

(Long Acting opioids, Immediate release opioids exceeding quantity limits and/or greater than 90 mg morphine equivalents (MME)/day)

For Internal Use Only
PA#:
Date Entered:

FAX Completed form to: (410)424-4751 **Questions? (888) 819-1043, option 4**

Member Information (Please Print Legibly):			Provider Information:	
NAME:			NAME:	*Special Notes*:
RECIPIENT ID #:			CONTACT:	
DOB:	SEX:	PPMCO ID#:	PHONE:	FAX:

Clinical Consideration: (if Yes to any of the following questions and drug is formulary, sign below. If No, and drug is formulary or non-formulary, complete the related drug request section(s) & attestations)

- ☐ **Y** ☐ **N** Patient receiving opioid due to cancer treatment. Cancer type:_____
- ☐ **Y** ☐ **N** Patient receiving opioid due to Sickle Cell disease
- ☐ **Y** ☐ **N** Patient is in hospice care
- ☐ **Y** ☐ **N** Patient is in Long Term Care (LTC) Facility
- ☐ **Y** ☐ **N** Patient receiving palliative care (ICD-10 diagnosis code of Z51.5) Other Diagnosis:_____

FORMULARY LONG ACTING & IMMEDIATE RELEASE OPIOID EXCEEDING QUANTITY LIMIT:

Drug Name Requested	Strength	Dosage/Frequency	Duration
Fentanyl transdermal patches (Duragesic)			
Methadone tablets for pain (5mg/10 mg)			
Morphine sulfate ER (MS Contin)			
Oxymorphone ER			

NON-FORMULARY LONG ACTING & NON-FORMULARY IMMEDIATE RELEASE OPIOID REQUESTS:
****office notes required for non-formulary opioid requests****

Drug Name Requested	Strength	Dosage/Frequency	Duration

Previous Formulary Trial(s):

Drug Name/Strength/Dosage	Date(s) & Duration of Trial	Treatment Outcome

***Attestation for Long Acting & Immediate Release Opioids exceeding quantity limit and/or 90 morphine milligram equivalents (MME). Attestation required for all of the following in order to receive PA:**

- ☐ **Y** ☐ **N** Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP)
- ☐ **Y** ☐ **N** Patient has/will have random Urine Drug Screens
- ☐ **Y** ☐ **N** Naloxone prescription was provided/offered to patient/patient's household
- ☐ **Y** ☐ **N** Patient-Prescriber Pain management/Opioid treatment Agreement/Contract signed and in patient's medical record

I certify the benefits of opioid treatment for this patient outweigh the risks of treatment.

Prescribers signature: _____ Date_____

For Internal Use Only	
☐ Approved:	Duration of Approval: _____ month(s)
☐ Denied:	Authorized By/Date: