PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

SHORT-ACTING OPIOID PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

Subscriber ID Number	Group Number

Patient Name	Patient Telephone Number	Date of Birth

Patient Address	City	State	Zip Code

MEDICATION INFORMATION

Drug Name	Strength	Requested Quantity **per Month**

Diagnosis

CLINICAL CRITERIA

1. Please check ALL that apply. The patient has pain associated with

☐ Cancer (please provide diagnosis_____)
☐ Hospice program, end-of-life care, or palliative care (please provide diagnosis_____)
☐ Sickle cell anemia
☐ Chronic pain
☐ None of the above

2. Is the patient currently utilizing opioid therapy on a consistent basis for chronic pain (defined as prescribed opioids for use for 90 out of the past 110 days)?	Yes	No

3. Please check ALL that apply. The patient has severe pain and

☐ Non-opioid therapies (e.g. nonsteroidal anti-inflammatory drugs [NSAIDs], acetaminophen) have provided an inadequate response or are inappropriate according to the prescriber
☐ The patient's history of controlled substance prescriptions has been checked using the state prescription drug monitoring program (PDMP)
☐ The patient or parent/guardian has been educated on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction

4. Based on the patient's clinical circumstances, is the prescribed amount of opioid warranted in order to adequately manage the patient's pain?	Yes	No

MEDICAL RATIONALE / REASON FOR DRUG THERAPY

PRESCRIBER INFORMATION

Physician Name	Phone	Fax

Physician Address	City	State	Zip Code

Suite / Building	Physician Signature	Date

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.