



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/chp-forproviders/pharmacy

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									
Preferred Long Acting Opioids:	<input type="checkbox"/> Butrans Patch		<input type="checkbox"/> Morphine Sulfate ER tablets			<input type="checkbox"/> Fentanyl Patch (except half strengths)			
	<input type="checkbox"/> Embeda		<input type="checkbox"/> Xtampza			<input type="checkbox"/> Tramadol ER			
Non-Preferred Long Acting Opioid:	Specify drug:								
Short Acting Opioid:	Specify drug:								
Are there any contraindications to formulary medications? If yes, please specify:					<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<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"/> 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									
Pain is due to ONE of the following:		<input type="checkbox"/> Active Cancer		<input type="checkbox"/> Sickle Cell		<input type="checkbox"/> Palliative/End of life		<input type="checkbox"/> Hospice	<input type="checkbox"/> N/A
Will member be on both an opioid AND a benzodiazepine?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will Naloxone be provided/offered?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is request for opioid naïve member?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member opioid tolerant?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Does member have moderate to severe pain?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is documentation provided along with rationale for use?			<input type="checkbox"/> Yes		<input type="checkbox"/> No
Was non-pharmacologic therapy tried PRIOR to prescribing opioids (PT, exercise, CBT OR weight loss)?							<input type="checkbox"/> Yes		<input type="checkbox"/> No
Was non-opioid therapy tried PRIOR to prescribing opioids (Topical diclofenac, NSAIDs, TCAs AND SNRIs OR anticonvulsants)?							<input type="checkbox"/> Yes		<input type="checkbox"/> No
Provider attestation that a signed treatment plan addresses the following (check that apply):		<input type="checkbox"/> Realistic goals for pain AND function		<input type="checkbox"/> Consequences of lost medication		<input type="checkbox"/> Consequences of obtaining controlled substances from other prescribers		<input type="checkbox"/> Member using ONE pharmacy	
Will member be advised of harm AND benefit before treatment AND periodically during treatment (increased risks of respiratory depression, combination use BNZ, risks to others in household, cognitive limitations AND side effects)?								<input type="checkbox"/> Yes	<input type="checkbox"/> No

Will treatment be prescribed at lowest effective dose?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Will treatment be reviewed within 1 - 4 weeks of starting therapy AND with any dose escalation AND re-evaluated every 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was there review of state's PMD/PDMP for controlled substances, with focus on opioid doses OR dangerous combinations?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was UDS reviewed prior to starting treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Were results of UDS consistent with prescribed controlled substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there evidence of substance use disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was evidence-based treatment arranged (for example MAT)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Is request for FEMALE of reproductive age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was counseling provided about opioid use during pregnancy AND about NAS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Additional Clinical Criteria					
<input type="checkbox"/> Long Acting Opioids					
Will member exceed 90 MME per day limit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was documentation submitted to support exceeding recommended limit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Was pain specialist consulted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is request for chronic pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was treatment initiated with IR opioid for at least TWO weeks prior to considering ER/LA opioid?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is request for Butrans patch?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documented need for opioid with lower risk for abuse AND noted concern that member, or member's household is at risk for abuse and diversion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is request for non-formulary agent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there inadequate response OR intolerance to ALL formulary LA opioids for 2 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is request for abuse-deterrent product?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is there documentation of trial and failure of Butrans patch for at least 2 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
			Is there documentation to indicate NEED for abuse deterrent product AND concern that member OR member's household is at risk?		
Is request for methadone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is female member pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
<input type="checkbox"/> Short Acting Opioids					
Will member exceed 90 MME per day limit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there documentation to support medical necessity of exceeding recommended MME OR day supply limit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Is request for non-formulary short-acting agent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there inadequate response OR intolerance to ALL formulary short-acting opioids?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was documentation submitted supporting continued use of short acting agent beyond 30 days AND when used in combination with long-acting agent?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Acute Pain - Pediatric Members <18 Years of Age					
Is request for acute pain (post-dental procedure)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was pain assessment completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has member AND their parent/guardian been screened for previous AND current opioid use?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did provider check state's PMD/PDMP for controlled substances with focus on opioid doses AND dangerous combinations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was concomitant use with BNZ addressed, IF present?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Will opioid therapy be used in COMBO with APAP and NSAIDs, unless contraindication is present for use of both?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was COMBO therapy with APAP and NSAIDs tried AND failed OR were there contraindications present for use of both?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is request for codeine OR tramadol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member <12 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is prescription limited to 8 – 12 tablets	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
Will IR opioids be prescribed at lowest effective dose AND not greater than expected pain duration? (NOTE: ≤3 days is recommended by CDC. >7 days will rarely be required)				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Renewal ONLY					
Was there sustained improvement in Pain OR Function?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was tapering plan initiated to D/C treatment of current medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A
Was UDS performed in past year?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
State's PMP was reviewed AND verified (check that apply):	<input type="checkbox"/> Prescriptions from other providers	<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> ER / LA use for acute pain	<input type="checkbox"/> UDS consistent with prescribed controlled substances	
Is dose ≥50 MME per day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did provider offer Naloxone to member?	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> N/A

Is dose \geq 90 MME per day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did provider refer member to Pain Specialist?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Is there continued concomitant use of opioid AND benzodiazepine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was member counseled on FDA BBW dangers of concomitant use AND provider will prescribe at LOWEST effective dose AND duration?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

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 833-711-0776 to check the status of a request.