

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 <a href="https://www.mercycareaz.org/providers/completecare-vww.mercycareaz.org/providers/completecareaz.org/pr forproviders/pharmacy

Opioids – Long and Short Acting Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently

Manchan Information	iads and medical testi	ng reieva	int to reques	t snowi	ng medical	ustificatio	n are require	a to support o	iiagnosis				
Member Information		Data of Dieth			1	0	11.1.1.6						
Member Name (first & last):		Date of Birth:				Gender		Height:					
Member ID:		City.				ale I	□ Female	\\/aimbt					
Member ID.		City:	Oily.		State:			Weight:					
Prescribing Provider Inf	ormation												
Provider Name (first & last):		Special	Specialty:		NPI#			DEA#	\#				
Office Address: City					State:			Zip Code:	Zip Code:				
Office Contact:			Office Pho	ne	Office Fax:								
Dispensing Pharmacy Ir	nformation												
Pharmacy Name:			Pharmacy Phone:				Pharmacy Fa	ax:	(:				
Requested Medication I	nformation												
Long-Acting Opioid:	Specify drug:												
Short Acting Opioid:	Specify drug:												
Are there any contraindica	ations to formulary medi	cations?			☐ Yes	□ No	□ New	☐ Contin	uation of				
If yes, please specify:							request	therap	y request				
Directions for Use:		S	trength:				Dosage Forr	n:					
		Q	Quantity:		Day Supply:		Duration of Therapy/Us		Jse:				
Medication request is NO	T for an EDA approved	or compe	andia [) Diagnosi	ie.		ICD-10 Code	a·					
supported diagnosis (circl	iluia- L	Jiagi losi	15.		ICD-10 Code	5.							
What medication(s) has m		No or this dia	gnosis? Plea	se spec	ify:								
Turn-Around Time for R	eview												
☐ Standard – (24 hours		□ Ur	gent – If wait	ing 24 h	ours for a st	andard dec	cision could se	riously harm lif	e health				
	-,		or ability to regain maximum function, you can ask for an expedited decision.										
		Si	gnature:										
Clinical Information													
	OIDS (Check all that ap	pply)											
☐ For use of MAT and			u matific tha mu		of the NAT	th a ramy A	ND the preseri	har - 1	1 = 1				
For Medication Assisted T of the MAT therapy appro	ves the concurrent opioi	d therapy	?			tnerapy, A	tne prescri	ber	□ No				
For a surgical procedure, will the day supply exceed 14									□ No				
·			s the day supply exceed 5 days?						□ No				
Has the member had a pr	evious approval in the la	st 6 mont	nonths?						□ No				
☐ Cancer Related Pair	n / Hospice Care / End-	of-Life C	are										
Is the member being treat	ed for cancer OR receiv	ing hospid	ce OR end-of-	life care	?			☐ Yes	□ No				
						ease tablet	s (generic MS	Contin)					
					transdermal								
The member has a history	y of failure, C/I, or		Tramadol	ER table	ets (non-biph	asic releas	e tablets)						
intolerance to a trial of at	least THREE of the		Xtampza E	R (oxy	codone ER)								
following:			☐ Butrans (buprenorphine)										
								75mcg & 100m	icg & 100mcg				
There was a HX of failure Document date of trial:	, C/I, or intolerance to B	OTH of th	e following:		tramadol ER	•	n-biphasic	□ tramado	ol IR				
Document date of that:					<u>release table</u>	ເວ <i>)</i>		L					

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Is the member ESTABLIS	HED on pa	ain therapy	/ with the	e reques	ted medica	tion AND th	ne medicat	tion is NOT a	new		Yes		No
regimen? Doses Exceeding Co	umulativa	MME of 0	Oma										
Cancer / Hospice / End-c				illed Nu	rsing Facili	itv / Traum	natic Iniury	/ Related Pa	in				
		ve oncolo			□ Hospic				f-life care				
Member has ONE of the	☐ Palli	iative care		1	□ Skilled	nursing fac	cility care	☐ Traum	atic injury	includ	ding bu	rns &	ı
following conditions:						J	,		ing post-s		_		
Does the prescriber attest that the member has been prescribed naloxone? (may also be verified via paid pharmacy claims)									Yes		No		
				ما م د ا :د.	- Cara Dair								
□ Non-Cancer Pain / N Are the treatment goals de											Yes		No
							armacolog	ic interventio	n?		Yes		No
Does the treatment plan include the use of a non-opioid analgesic AND/OR a non-pharmacologic intervention? Has the member been screened for substance abuse/opioid dependence?										Yes		No	
·										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?									162		INO		
Is the pain moderate to se	vere AND	expected	to persis	t for an	extended p	eriod of tim	ie?				Yes		No
Is the pain chronic?] Yes	□ No	Is pain opioid		ement requi	red around	the clock	with a long-a	cting		Yes		No
Is the Pain NOT postopera		, obrania a	nioid the	rony pri	or to ourgon	v OB if the	naatanar	ativo nain ia d	wheeted		Yes		No
(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)										N.			
last 30 days? Document d	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						Yes		No					
to a MAX therapeutic dose? If yes, document date of trial:													
				-				the tricyclic			Yes		No
Desire Franchise C	\	- NANAT	00		antidepres		•						
□ Dosing Exceeding C Non-cancer / Non-Hospic				Palliativ	e Care / No	n-Skilled	Nursing F	acility / Trau	matic Inj	ıry Re	lated	Pain	
		FO provide	ed is		TX goals ar	re e	□ TX	plan includes		MB	R has l	oeen	
Prescriber attests to ALL		e & accura st of provi			defined, inc			a non-opioid algesic and/or		screened for substance			
of the following:		owledge			TX		non	n-pharmacolo		abu	se/opi	oid	
	□ If u	ised in MF	RRS with	medica	l comorbidit	ties OR if u		rvention rrently with a	BNZ OR /		enden		uld
	pot		ause DD	I, the pro	ovider has a			ave complete					
Has the member T/F NON											Yes		No
Drug Name: Date of Trial:													
Does the prescriber attest that the member has been prescribed naloxone? (may also be verified via paid pharmacy claims)								Yes		No			
Can the requested dose be			a to a bi	abor otr	onath of the	nroduot?				Т	Yes		No
Is the requested dose with						-	er day evis	ete?			Yes		No
☐ Opioid Naïve (Not ha				-		iAX dose p	er day exis	313 :			103		140
		□ No	Diagno			ncer 🗆	End of life	e pain	□ Palli	ative		Sickl	le cell
MME to 90 MME?			ONE o	f the ng:			(including	g hospice)	care			aner	
Is the member currently exthe past 120 days?	ceeding 5	0 MME A	ND pres	criber at	tests that m	ember has	been on s	short-acting o	pioid in		Yes		No
Is the diagnosis associated		need for p	ain	□ Ye	s 🗆 No			al comorbiditi	-		Yes		No
management with an opio	id?							a BNZ or oth DDI's, has th					
						prescri	ber acknov	wledged that	they have				
								sessment of in y depression					
Has the prescriber acknow	vledged that	at they ha	ve	□ Ye	s 🗆 No			er attest that t			Yes		No
completed an addiction ris	completed an addiction risk AND a risk of overdose member requires >50 MME/day to												
assessment? adequately control pain?													
☐ Renewal Requests (ol pain?					

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I improvement in p	r demonstrate a ain and function		'	□ Yes				ationale for NC uing the opioid		ering and		Yes		No						
If yes, document		•						cument ration												
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?									nn?		Yes		No							
Has the member been screened for substance abuse/opioid dependence?																				
·									. 11 . 1		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								
	ne pain moderate to severe AND expected to persist for an extended period of time?										Yes		No							
Is the pain chronic	c? ☐ Yes	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)								expected		Yes		No								
Prior to start of th						with a short-	-acting	opioid within	last 30) days?		Yes		No						
Drug(s)								·												
Date of trial:																				
☐ SHORT-ACT	TING OPIOIDS (Check all	that app	y)																
☐ For use of N	MAT and other (Opioids																		
For Medication A							of the	MAT therapy	AND	the		Yes		No						
prescriber of the l							duro?					Yes		No						
For a surgical procedure, will the day supply exceed 14 days for a surgical procedure? For all other requests besides surgical procedure, does the day supply exceed 5 days?									Yes											
Has the member		• .		•	suppiy	y exceed 5	uays:				_	Yes								
□ Non-Preferr	•	аррготагиг	the last c	, monuto.								163	1"	INO						
HX of failure,	□ hydromor	phone [codone-		tramadol		oxycodone		butalbital-] mo	orphir	ie						
C/I, or	(Dilaudid))	APAF (Nord		((Ultram)		-ibuprofen		APAP-caff		su	lfate							
intolerance to at least FIVE			(INOIC	0)						w/ cod										
PREFERRED	☐ hydrocode	one- F] охус	ndone		oxycodone		APAP w/		(Fioricet)	Г	□ me	eperio	line						
short-acting	ibuprofen		-	codone)		w/ APAP		codeine		ASA-caff	-		- p							
opioids:					((Percocet)				w/cod										
□ PA Require	for > 2 Short	Acting Oni	oide							(Fiorinal)	(Fiorinal)									
=	□ PA Required for > 2 Short Acting Opioids																			
, , ,										□ Yes	Тп	No	Ιп	N/A						
•	nedication being	used for a	djusting		os cribe	ed drug an	d NIOT	in addition to	it?	☐ Yes				N/A						
Is the requested r	medication being	used for a	djusting	eviously pro					it?	☐ Yes		No		N/A						
•	medication being medication to be medication a dos	used for a used in pla sage form t	djusting	eviously pro					it?											
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Is the requested reduced reduc	medication being medication to be medication a dos NOT in addition an attest they are medically necessit requested due to dose fall with a 5-day Supply of the ms OR	used for a used in place and in to it? e aware of essary? o dose carrin FDA app Active once Hospice carrin FDA app ME AND p Used in MI concurrent potentially	ace of precord by the second of the second o	eviously production place of the high attests ME dical como NZ or other of the high attest of the high attention of the	moviner day f-life ive BR has rbiditier drugse pres	pioids presong to a higher, where an Skille Cancer	er streed nur	medication AND feel TX v ngth of the production of the productio	oduct? day ex are [past 1]	☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Yes☐ Chronic provider☐ Traumar post-sur☐ Palliative care☐ 20 days?☐	concorrectic injugical	No No No No Yes Yes littions vived F ury, ex proce an Yes Pres attes	offor when the control of the contro	N/A N/A N/A N/A No No nich proval ng sell No						

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	/ End of Life / Pallia				ry Related Pain Exceeding 90 MME			
☐ Active oncology	☐ Hospice ☐	Skilled nursing fa	icility End-o	f-life care	☐ Traumatic injury, including burns &			
					excluding post-surgical procedures			
□ Non-cancer / Not Exceeding 90 MM		of-life / Non-palliati	ive care / Non-skil	led nursing f	facility / Non-traumatic injury related pain			
☐ TX goals are defir	_	·	des use of non-opic	•	☐ MBR has been screened for			
estimated duration			n-pharmacologic intervention substance abuse/opioid dep					
	edical comorbidities C				rovided is true & accurate AND a routine			
	ould cause DDI, AND							
-	n assessment of incre				90 MME have been tried AND did not			
			adequately cor		90 MME have been thed AND did not			
Orug:			Drug regimen or MI	ME:				
Date of trial:			Dates of Therapy: _					
Additional informatio	n the prescribing pro	vider feels is impo	rtant to this review	w. Please sp	ecify below or submit medical records.			
Signature affirms the	at information given	on this form is true	and accurate and	l reflects offi	ce notes.			
Prescribing Provide	'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 800-624-3879 to check the status of a request.

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