

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 E	Date of Birth:			Geno	der:					
						□ Male □ Fen						
Member ID: City:				State:			Weight:	Weight:				
Prescribing Provider Inform	nation											
Provider Name (first & last): Spec			cialty:		NPI#		D		DEA#			
Office Address:	City:		State:			Zip Code:						
Office Contact:		Office Phone			(Office Fa	1					
Dispensing Pharmacy Inform	mation											
Pharmacy Name:			Pharma	cy Pho	ne:		Phar	macy Fa	ax:	:		
Requested Medication Infor	mation											
Long-Acting Opioid: Sp	pecify drug:											
Short Acting Opioid: Sp	pecify drug:											
Are there any contraindication	ns to formulary medic	ations?			□ Yes		o 🗆	New		nuation of		
If yes, please specify:								request		py request		
Directions for Use:	Str	ength:				Dos	age Forn	n:				
	Qu	iantity:		Day Supply	:	Dura	Duration of Therapy/Us					
Medication request is NOT for		ndia- Di	s:		ICD-	ICD-10 Code:						
supported diagnosis (circle on	No r this diag	diagnosia? Diagon anosify										
What medication(s) has member tried and failed for this diagnosis? Please specify:												
Turn-Around Time for Revie	ew .											
Standard – (24 hours)		🗆 Urg	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.									
Clinical Information		Sig	nature:									
	S (Chock all that an											
□ For use of MAT and oth		piy)										
For Medication Assisted Treat		e provider	notify the pre	scriber	of the MAT	therapy.	AND the	e prescril	ber 🛛 Yes	□ No		
of the MAT therapy approves	therapy?	apy?										
For a surgical procedure, will the day supply exceed 14							□ Yes	🗆 No				
For all other requests besides surgical procedure, does				days?				🗆 No				
Has the member had a previo	st 6 month	ionths?				□ Yes	🗆 No					
Cancer Related Pain / Hospice Care / End-of-Life Care												
Is the member being treated for	ng hospice	e OR end-of-li	ife care	?				□ Yes	🗆 No			
					ontrolled rele	ease tab	olets (ger	neric MS	Contin)			
The member has a history of f	failure C/L or				transdermal							
intolerance to a trial of at least			Tramadol E	R table	ts (non-biph	asic rele	ease table	ets)				
following:			Xtampza El									
			Butrans (bu									
T							75mcg & 100					
There was a HX of failure, C/I Document date of trial:	I H of the	tollowing:		ramadol ER elease table		(non-bipł	nasic	□ tramad	IOLIK			

Is the member ESTABLIS regimen?	HED on pair	n therapy with t	he reques	sted medicatio	on AND th	e medicatio	on is NOT a new		Yes		No
Doses Exceeding C	umulative N	MME of 90ma								1	
Cancer / Hospice / End-of-Life / Palliative Care / Skilled Nursing Facility / Traumatic Injury Related Pain											
		e oncology diag					End-of-life car	e			
Member has ONE of the following conditions:	Palliat	tive care		Skilled nu	ursing fac	ility care	Traumatic inju	-	-		L
Deep the properties attact	that the man		n ro o o rib o	d palayapa0			excluding pos				Na
Does the prescriber attest (may also be verified via p			prescribe	ed naloxone?					Yes		No
Non-Cancer Pain / N		· ·	nd-of-Lif	e Care Pain						I	
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 scr		•	-						Yes		No
If used in members with m	edical como	orbidities OR if	used cond	currently with	a benzodi	iazepine or	other drugs that		Yes		No
could potentially cause dru assessment of increased r	ug-drug inter	actions, has th	e prescrib								
Is the pain moderate to se	vere AND ex	xpected to pers	sist for an	extended peri	iod of time	e?			Yes		No
Is the pain chronic?] Yes [ement require	d around	the clock w	ith a long-acting		Yes		No
Is the Pain NOT postopera	ative?	opioi	u :						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)								b			
								Yes		No	
Is the request for neuropat	thic pain?	□ Yes	🗆 No				e to 8 weeks of TX	D be	Yes		No
with gabapentin AND a tricyclic antidepressant titrated to a MAX therapeutic dose?								50			
				If yes, docun	nent date	of trial:	0		M		N1.
				Is there a C/ antidepressa		bentin or to	the tricyclic		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											
Non-cancer / Non-Hospie		D provided is		TX goals are	-Skilled r				R has		
		& accurate to		defined, inclu	ding		non-opioid		eened		
Prescriber attests to ALL		of provider		estimated du	ration of		gesic and/or		substance		
the following:	KNOV	vledge		ТХ			pharmacologic vention		use/opio benden		
						sed concur	ently with a BNZ O	R other	drugs tl	nat co	
		ntially cause D for respiratory o			knowledge	ed they hav	/e completed an as	sessmei	nt of inc	rease	ed
Has the member T/F NON									Yes		No
Drug Name:				Date of Tr	rial:						
Does the prescriber attest (may also be verified via p			prescribe	ed naloxone?					Yes		No
Criteria for Quantity	Limit Revie	ews									
Can the requested dose b			-	•					Yes		No
Is the requested dose with					X dose pe	er day exist	is?		Yes		No
Opioid Naïve (Not ha						End of life				Siek	
Is the request for 50 DMME to 90 MME?] Yes [nosis for of the vina:	□ Canc	er 🛛	(including		alliative are		aner	le cell nia
Is the member currently ex the past 120 days?	ceeding 50			tests that mer	nber has l	been on sh	ort-acting opioid in		Yes		No
Is the diagnosis associated		eed for pain	🗆 Ye	es 🗆 No			comorbidities OR		Yes		No
management with an opio	id?						BNZ or other drug DI's, has the	S			
							ledged that they ha	ve			
					complet		essment of increase				
						no on ! 1					
Has the prescriber acknow	ledged that	they have				respiratory			Vec		No
Has the prescriber acknow completed an addiction ris			□ Ye	es 🗆 No	Can the member	e prescriber r requires >	attest that the 50 MME/day to		Yes		No
	k AND a risł		□ Ye	es 🗆 No	Can the member	e prescriber	attest that the 50 MME/day to		Yes		No

	r demonsti ain and fui	rate a meaning nction?	gful		Yes				rationale for No uing the opioid		ering and		Yes		No
If yes, document									ocument 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?									on?		Yes		No		
Has the member	•				•			· ·					Yes		No
								benzodia	azepine or othe	er drug	s that		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?															
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 p				1.0									Yes		No
(Unless member to be moderate to								JR if the	postoperative	pain is	expected				
Prior to start of th	erapy, was	s there failure	with a M	N of 2	weeks	, trial	with a sł	hort-actin	g opioid within	last 3	0 days?		Yes		No
Drug(s)															
Date of trial:															
		DIDS (Check a		pply)								1			
		ther Opioids												1	
For Medication As prescriber of the I								iber of the	e MAT therapy	, AND	the		Yes		No
For a surgical pro	cedure, w	ill the day sup	ply excee	ed 14 da	ays for	a su	rgical pro	ocedure?					Yes		No
For all other requ	ests besid	es surgical pro	ocedure,	does th	ie day	supp	ly excee	d 5 daysî	?				Yes		No
Has the member	had a prev	vious approval	in the la	st 6 mo	nths?								Yes		No
□ Non-Preferr			1												
HX of failure,	-	romorphone		drocod	one-		tramado		oxycodone		butalbital-	[rphir	e
C/I, or intolerance to at	(Neree)							APAP-caπ w/ cod		sui	fate				
least FIVE (Fioricet)															
PREFERRED	□ hyd	rocodone-	□ ox	ycodon	e		oxycodd	one 🗆	APAP w/		butalbital-	[⊐ me	peric	line
short-acting ibuprofen (Roxicodone) w/ APAP codeine ASA-caff															
opioids: (Percocet) w/cod (Fiorinal)															
Image: PA Required for > 2 Short Acting Opioids (Fiorinal)															
PA Require	d for > 2 S	hort Acting (Opioids							-	(Florinal)				
PA Required Is the requested r		-	-	ng the d	dose?								No		N/A
-	nedication	being used for	or adjusti			escrib	bed drug	, and NO	T in addition to	o it?					N/A N/A
Is the requested r	nedication nedication	being used for to be used in	or adjusti place of	previou	usly pre		-			o it?	□ Yes		No		
Is the requested r Is the requested r Is the requested r dosage form, and	nedication nedication nedication NOT in ad	being used for to be used in a dosage for ddition to it?	place of m to be u	previou sed in	usly pro place c	of pre	viously p	orescribe	d medication		□ Yes □ Yes □ Yes		No No		N/A N/A
Is the requested r Is the requested r Is the requested r dosage form, and Does the physicia	nedication nedication nedication NOT in ad	being used for to be used in a dosage for ddition to it? ey are aware	place of m to be u	previou sed in	usly pro place c	of pre	viously p	orescribe	d medication		□ Yes □ Yes		No No		N/A
Is the requested r Is the requested r Is the requested r dosage form, and	nedication nedication nedication NOT in ad n attest th medically	being used for to be used in a dosage for ddition to it? ey are aware	place of m to be u	previou sed in	usly pro place c	of pre	viously p	orescribe	d medication		□ Yes □ Yes □ Yes		No No		N/A N/A
Is the requested r Is the requested r Is the requested r dosage form, and Does the physicia all medications is	nedication nedication nedication NOT in ad n attest th medically nit	being used for to be used in a dosage for ddition to it? ey are aware necessary?	place of place of m to be u of MULT	previou sed in _I IPLE sł	usly pro place o nort-ac	of pre	viously p	orescribed rescribed	d medication	with	Yes Yes Yes Yes Yes Yes		No No		N/A N/A
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Is the requested r Is the requested r Is the requested r dosage form, and Does the physicia all medications is Quantity Lir Is the dose being Does the request Greater than Member has ONE following conditio care instances: Opioid Naïv Is the request for MME to 90 MME ^C Is MBR currently DX is associ with need for	nedication nedication NOT in ac nattest th medically nit requested ed dose fa 5-day Su of the ns OR e (Not hav 50	being used for to be used in a dosage for ddition to it? ey are aware necessary? due to dose Il within FDA a ipply Active of Hospice ring filled an Yes D N 50 MME AND	or adjustii place of m to be u of MULT cannot b approved oncology e care opioid ir ON follo	Previou sed in p IPLE sh e achie MAX c MAX	usly pro place of nort-ac eved by dose po End-of care Palliat care 120 da is for es	of pre ting c / mov er day f-life ive ys) BR ha rbiditi	viously p opioids p ring to a y, where Cance s been o ies OR u	higher sti an FDA Skilled nu Post-surg	d medication	with day ex are s	Yes Trauma post-sur Palliative care 20 days?		No No Yes Yes ditions f eived P jury, ex proceed Sice and Yes	i i i i i i i i i i i i i i i i i i i	N/A N/A N/A No No nich proval ng ell No
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	Cancer / Hospice	/ End of Life / Palli	ative Care/Skilled	Nursing Facility / T	raumatic Injur	y Related Pain Exceeding 90 MME	
	Active oncology		□ Skilled nursing			☐ Traumatic injury, including burns &	
L		-	-			excluding post-surgical procedures	
			l-of-life / Non-palli	ative care / Non-ski	lled nursing fa	acility / Non-traumatic injury related pain	
	Exceeding 90 MM						
	TX goals are define	-		ludes use of non-opi	0	□ MBR has been screened for	
	estimated duration			on-pharmacologic int		substance abuse/opioid dependence	
		edical comorbidities				ovided is true & accurate AND a routine	
	-	ould cause DDI, ANE		• •		d request of medical information may be	
_		assessment of incr				ary to verify the accuracy of INFO provided	
	MBR I/F a NON-o	pioid pain medicatio	1:			0 MME have been tried AND did not	
Dru	a.			adequately co	•		
				Drug regimen or M	IME:		
Dai				Dates of Therapy:			
Add	litional information	n the prescribing p	ovider feels is im	portant to this revie	w. Please sp	ecify below or submit medical records.	
ł							
I							
01	Signature affirms that information given on this form is true and accurate and reflects office notes.						
SIG	gnature attirms tha	t information giver	on this form is tr	ue and accurate and	u retiects offic	e 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.