



Request for Prior Approval Short-Acting Opioid Analgesic

Recipient Information

1. Recipient Last Name: 2. First Name: 3. Recipient ID #: 4. Recipient Date of Birth: 5. Recipient Gender:

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: NPI: or Atypical: 8. Prescriber DEA #: 9. Requester Contact Information: Name: Phone #: Ext:

Drug Information

9a. Drug Name: 9b. Is this request for a Non-Preferred Drug? 10. Strength: 11. Quantity Per 30 Days: 12. Length of Therapy (in days):

Clinical Information

1. Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? 2. Does the beneficiary have a diagnosis of chronic pain syndrome of at least four (4) weeks duration? 3. Is the requested daily dose in combination with other concurrent opioids less than or equal to 90mg of morphine or an equivalent dose? 3a. Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits. 3b. Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose. 4. Is this an initial authorization request? 4a. If Yes, has the beneficiary tried a short-acting Opioid Analgesic in the past 45 days? 4b. If no, explain: 5. Has the prescriber reviewed and is adhering to the N.C. Medical Board statement on the use of controlled substances for the treatment of pain? 6. Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate? 7. Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System? 8. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? Non-Preferred Products: 9. Does the patient have a documented history within the past year of two preferred long-acting Opioid Analgesics at a dose equal to or equivalent to the non-preferred long-acting Opioid Analgesic being prescribed? 10. Does the patient have a contraindication or allergy to ingredients in the preferred product? Signature of Prescriber: Date:

Fax this form to: (800) 678-3189 Pharmacy PA Call Center: (866) 799-5318