

Request for Prior Approval Long-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 #: _____
 Requester Contact Information: Name: _____ Phone #: _____ Ext: _____

Drug Information

9a. Drug Name: _____ 9b. Is this request for a Non-Preferred Drug? Yes No
 10. Strength: _____ 11. Quantity Per 30 Days: _____
 12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other: _____

Clinical Information

1. Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? Yes No If yes, the patient is exempt from the prior authorization requirement

2. Does the beneficiary have a diagnosis of chronic pain syndrome of at least four (4) weeks duration? Yes No

3. **Is the requested daily dose in combination with other concurrent opioids less than or equal to 90mg of morphine or an equivalent dose?** Yes No
 Answer questions 3a and 3b when the response to question 3 is 'No'.

3a. Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits.
 Please list: _____

3b. Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose.
 Please list: _____

4. Is this an initial authorization request? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
 Yes No

4a. If Yes, has the beneficiary tried a short-acting Opioid Analgesic in the past 45 days? Yes No
 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? Yes No

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? Yes No

7. Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System? Yes No

8. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? Yes No

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? Yes No
 Please list: _____

10. Does the patient have a contraindication or allergy to ingredients in the preferred product? Yes No
 Please list: _____

Signature of Prescriber: _____ Date: _____