carolina complete health

Pharmacy 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 #: _____
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 ☐ 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. Is this an initial authorization request? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
☐ Yes ☐ No
2a. If No, please attach documentation as to why the beneficiary needs continued opioid treatment and current plan of care.
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. 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
5. 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
6. Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System? ☐ Yes ☐ No
7. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? ☐ Yes ☐ No
<u>Non-Preferred Products:</u>
8. Does the patient have a documented history within the past year of two preferred short-acting Opioid Analgesics at a dose equal to or equivalent to the non-preferred short-acting Opioid Analgesic being prescribed? ☐ Yes ☐ No
Please list: _____
9. Does the patient have a contraindication or allergy to ingredients in the preferred product? ☐ Yes ☐ No
Please list: _____

Signature of Prescriber:_____ Date:_____
*Prescriber signature mandatory

Fax this form to: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309