



Pharmacy Prior Approval Request for
Short-Acting Opioid Analgesic

Beneficiary Information

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

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days Other: _____

Clinical Information

1. Does the member have a diagnosis of malignant cancer or pain due to neoplasm? **Yes** **No** If yes, the member is exempt from the prior authorization requirement
2. Does the member have Sickle Cell Disease? **Yes** **No**
3. Is this an initial authorization request? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
 Yes **No**
3a. **If No, please attach documentation as to why the beneficiary needs continued opioid treatment and current plan of care.**
4. **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'.
4a. Please supply the member's diagnosis and reason for exceeding dose per day limits.
Please list: _____
4b. Please provide the duration (days' supply) the member will exceed the limit of 90mg of morphine or an equivalent dose.
Please list: _____
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 member 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 member'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**

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Non-Preferred Products:

9. Does the member 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 member have a contraindication or allergy to ingredients in the preferred product? Yes No

Please list: _____

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.