# Extended-Release Opioid Prior Authorization Form

CareSource

Please Fax Form To: 866-930-0019
Date Of Request: _____

## Patient Information

Member Name: _____ CareSource ID: _____
Member DOB: _____ Gender: M / F
Pharmacy: _____ Pharmacy Phone #: _____

## Prescriber Information

Name: _____ NPI/DEA: _____ Specialty: _____
Address: _____
Office Contact: _____ Phone: _____ Fax: _____

## Diagnosis & Required Information

- ☐ Diagnosis Code (ICD-10): _____
- ☐ Prescriber attests to reviewing state prescription drug monitoring program (PDMP) prior to writing prescription. Date: _____
- ☐ Prescriber attests benefits and risks of opioid therapy have been discussed with patient.
- ☐ Prescriber attests to a documented patient-specific treatment plan (e.g., assessment of pain and function scores, a baseline urine drug test, plans for random urine drug screens, opioid contract, etc.)
- ☐ Prescriber attests to periodic assessment of patient's outcomes (e.g., adherence, progress notes documenting pain and function scores, random urine drug screens, no serious adverse outcomes) to ensure that continued therapy outweighs risk to patient safety.
- ☐ Prescriber attests to reassessment of patient's addiction risk or mental health concerns (e.g., using Screening, Brief Intervention, and Referral to Treatment [SBIRT] tools), including referral to an addiction medicine specialist when appropriate.
- ☐ If the patient is taking a benzodiazepine, prescriber affirms to assessment to ensure benefit outweighs the risk of benzodiazepine use along with the opioid analgesic.
- ☐ If patient's cumulative dose of opioids is above 80 MED per day, prescriber must be a pain specialist or must attest to consulting a pain specialist. If pain specialist is unavailable, provide documentation supporting so and rationale for higher dose.
- ☐ Member tried a short-acting opioid for at least the last 60 days. Please list drugs that have been tried.

| Medication Name | Date Started | Trial Length | Reason For Discontinuation/ Contraindication |
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## Extended-Release Opioid Requested

| Drug Name: | Strength: |
|---|---|

| Quantity: | SIG: | Dosage Form: |
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If member is currently treated on this medication, please list start date:

Which limits you are requesting to exceed? (Circle all that apply)

| Initiating Long-Acting Opioid Therapy | > 90 Days of Therapy | > 80 MED Per Script (MED= Morphine Equivalent Dose) |
|---|---|---|

Reason for Request:

Physician Signature: _____ Date: _____