PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Long Acting Opioids

SERVE YOU Rx

Phone: 800-759-3203 Fax back to: 800-480-4840

Serve You Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Plan Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty:	

Drug Name and Strength: ☐ Urgent Review Requested

Directions:

Expected Duration of Therapy:

If this is a continuation of therapy, provide start date:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please indicate if this request is for:

☐ New Start ☐ Continuation of Therapy

Q2. Please indicate the diagnosis for use:

Q3. Please provide expected duration of treatment:

Q4. Is the patient being treated for cancer related pain or pain associated with end of life? (If yes, please answer questions #5 and #6, if applicable. No other questions need to be answered).

☐ Yes ☐ No

Q5. For requests for Arymo ER, brand Kadian, Morphabond ER, Nucynta ER, Xtampza ER, or Zohydro ER, does the patient have a history of failure, contraindication, or intolerance to at least two of the following: (please see below)

☐ Yes ☐ No

Q6. Please indicate which medications the patient has tried and failed:

- ☐ Generic hydromorphone ER
- ☐ Generic morphine sulfate ER
- ☐ Generic oxymorphone ER
- ☐ Embeda
- ☐ Hysingla ER
- ☐ Oxycontin

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Long Acting Opioids

SERVE YOU Rx

Phone: 800-759-3203 Fax back to: 800-480-4840

Serve You Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**

Q7. Has the patient tried and failed an adequate (minimum of 4 week) trial of a short-acting opioid?

☐ Yes ☐ No

Q8. For NON-NEUROPATHIC PAIN, is the medication being used for any of the following (see Question #9 below)?

☐ Yes ☐ No

Q9. Please indicate if any of the following apply:

☐ For use as an as-needed PRN analgesic
☐ For pain that is mild or not expected to persist for an extended period of time
☐ For acute pain

Q10. For POSTOPERATIVE PAIN, do either of the following apply? (see below)

☐ Yes ☐ No ☐ NA

Q11. Please indicate which of the following apply:

☐ Patient was already receiving chronic opioid therapy prior to surgery ☐ Postoperative pain is expected to be moderate to severe and persist for an extended period of time

Q12. For NEUROPATHIC PAIN, has the patient exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose?

☐ Yes ☐ No

Q13. For NEUROPATHIC PAIN, has the patient exhibited an adequate response to at least 6-8 weeks of treatment with a tricyclic antidepressant titrated to a therapeutic dose?

☐ Yes ☐ No

Q14. For continuation of therapy, is documentation available that addresses ALL of the following? (please see Question #15 below, please provide such documentation)

☐ Yes ☐ No

Q15. Please indicate which of the following apply:

☐ Treatment goals and estimated duration of treatment
☐ Treatment plan including use of nonopioid analgesics and/or nonpharmacologic intervention
☐ Evidence that the patient has demonstrated meaningful improvement in pain and function using a validated instrument
☐ Evidence that the patient has been screened for substance abuse/opioid dependence using a validated instrument
☐ Evidence that the patient has been screened for comorbid mental health conditions
☐ An assessment of increased risk for respiratory depression, if applicable based on medical comorbidities and/or drug-drug interactions (e.g. benzodiazepines)
☐ Total daily morphine equivalent dose
☐ Evidence that the prescriber has identified concurrently prescribed controlled substances from state PDMP

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Long Acting Opioids

SERVE YOU Rx

Phone: 800-759-3203 Fax back to: 800-480-4840

Serve You Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**

☐ Rationale for not tapering or discontinuing the opioid
Q16. Additional comments:

Prescriber Signature

Date

Certain prescription benefit plans or situations may require additional information or clarification to evaluate a prior authorization request. For complete details about benefits, limitations, conditions and exclusions, please refer to the applicable plan.