



Prior Authorization for Chronic Opioid Use
(More than 90 Days)

Fax Completed Form to 740-305-0596
If Urgent, please call 740-661-4463 (M-F 9am-7pm EST)

Patient Information

Injured Worker's Name: _____
Injured Worker's Date of Birth: _____
Claim #: _____
Date of Injury: _____
Member ID: _____

Prescriber Information

Prescriber Name: _____
Prescriber NPI: _____
Prescriber Phone: _____
Prescriber Fax: _____

The patient is under my care for the treatment of _____ ICD 10: _____

This treatment is related to the patient's workers' compensation injury: Yes No

This Request is for (Medication Name): _____

Strength: ____ Quantity: ____ Day Supply: ____ Date of Service: _____ Rx # (if known): _____

Pharmacy Name and Location # (if known): _____ Pharmacy Phone: _____

Monitoring:

Have you rechecked your State's Prescription Drug Monitoring Program? Yes No

Have you screened the patient for risk of addiction? Yes No

Have you performed a urine drug test in the last year? Yes No

Average Pain Score:

Average Function Score:

Concurrent drug use:

Is the patient being treated with parenteral pain management? Yes No

Will the patient be using benzodiazepines concurrently with opioids? Yes No

Weaning:

Will you attempt to wean down the opioids in the next 90 days? Yes No

Please note the request for additional information on second page of this document

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Dosing:

What is the average Morphine Equivalent Dose (MED) prescribed?

For assistance: https://www.ohiopmp.gov/MED_Calculator.aspx

Coverage for Specified Drugs:

Fentanyl: Mark one of these conditions:

- Inability to swallow GI absorption problems Intolerable adverse effects
- Other: (Details):

Methadone: Did you complete a 12 lead ECG? Yes No

Opioid detox agent: Is the buprenorphine product being prescribed to treat opiate addiction?

- Yes No

Other non-preferred drug: Select the reason(s) preferred drugs are not used and what preferred drugs have been tried.

- An adverse reaction A drug-drug interaction A contraindication
- Inadequate response

Preferred Drugs tried:

Please include preferred medication names, strengths, and doses

Physician Signature

Date

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