# 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)

alius health
The difference is clear

## 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 addtional information on second page of this document**

## 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 problen ☐ 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**