



**Prior Authorization Request Form
Acute Opioid Use (90 Days or Less)**

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

Patient Information

Name: _____
Date of Birth: _____
Claim #: _____
Date of Injury: _____

Prescriber Information

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

The patient is under my care for the treatment of _____

ICD 10 Code(s): _____

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

This Request is for (medication): _____
Quantity _____ Day Supply: _____ Brand Medically Necessary: _____
If Brand Medically Necessary marked, please explain why: _____

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

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

Average pain score: _____

If pain is mild to moderate, did the patient try non-opioid therapy first? Yes No

Average function score: _____

Non-preferred drug: Select the reason(s) preferred drugs are not used: An adverse reaction
 A drug-drug interaction Inadequate response A contraindication

Preferred Drugs tried:

If applicable:

Surgery-related pain: Is the medication being used for post-op pain? Yes No

Opioid detox agent: Is the buprenorphine product being prescribed to treat opiate addiction? Yes No

Physician Signature

Date

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