# 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**