



Prior Authorization Request Form 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

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: _____

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

Dosing:

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

For assistance: <https://www.oregonpainguidance.org/opioidmedcalculator/>

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Coverage for Specified Drugs:

Fentanyl: Mark one of these conditions:

- Inability to swallow
- GI absorption problems
- Intolerable adverse effects
- Other: _____

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

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:

Physician Signature

Date

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