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**