AmeriHealth Caritas North Carolina

# Pharmacy Request for Prior Approval – Short-Acting Opioid Analgesics

**Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

**Prescriber Information**

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

**Drug Information**

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: __up to 30 days __60 days __90 days __120 days __180 days __Other: _____

**Clinical Information**

1. Does the beneficiary have a diagnosis of malignant cancer or pain due to neoplasm? Yes___ No___
*If yes, the beneficiary is exempt from the prior authorization requirement.
2. Does the patient have Sickle Cell Disease? Yes___ No___
3. Is this an initial authorization request? ('Yes' for an initial authorization; 'No' for a reauthorization request.) Yes___ No___
3a. If No, please attach documentation as to why the beneficiary needs continued opioid treatment and current plan of care.
4. **Is the requested daily dose *in combination with other concurrent opioids* less than or equal to 90mg of morphine or an equivalent dose?** Yes___ No___ Please answer questions 4a and 4b when the response to question 4 is 'No'.
4a. Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits. Please list: _____
_____
4b. Please provide the duration (day supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose.
Please list: _____
5. Has the prescriber reviewed and is adhering to the N.C. Medical Board statement on the use of controlled substances for the treatment of pain? Yes___ No___
6. Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate? Yes___ No___
7. Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System? Yes___ No___
8. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? Yes___ No___

**Non-Preferred Products:**

9. Does the patient have a documented history within the past year of two preferred short-acting Opioid Analgesics at a dose equal to or equivalent to the non-preferred short-acting Opioid Analgesic being prescribed? Yes___ No___
Please list: _____
10. Does the patient have a contraindication or allergy to ingredients in the preferred product? Yes___ No___
Please list: _____

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406**