Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Opioids – Long and Short Acting
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information			
Preferred Long Acting Opioids:	☐ Butrans Patch	☐ Morphine Sulfate ER tablets	☐ Fentanyl Patch (except half strengths)
	☐ Embeda	☐ Xtampza	☐ Tramadol ER
Non-Preferred Long Acting Opioid:	Specify drug:		
Short Acting Opioid:	Specify drug:		

Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	Diagnosis:	ICD-10 Code:
What medication(s) has member tried and failed for this diagnosis? Please specify:		

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information								
Pain is due to ONE of the following:	☐ Active Cancer	☐ Sickle Cell	☐ Palliative/End of life	☐ Hospice	☐ N/A			
Will member be on both an opioid AND a benzodiazepine?	☐ Yes	☐ No	Will Naloxone be provided/offered?	☐ Yes	☐ No	☐ N/A		
Is request for opioid naïve member?	☐ Yes	☐ No	Is member opioid tolerant?	☐ Yes	☐ No	☐ N/A		
Does member have moderate to severe pain?	☐ Yes	☐ No	Is documentation provided along with rationale for use?	☐ Yes	☐ No			
Was non-pharmacologic therapy tried PRIOR to prescribing opioids (PT, exercise, CBT OR weight loss)?	☐ Yes	☐ No						
Was non-opioid therapy tried PRIOR to prescribing opioids (Topical diclofenac, NSAIDs, TCAs AND SNRIs OR anticonvulsants?	☐ Yes	☐ No						
Provider attestation that a signed treatment plan addresses the following (check that apply):	☐ Realistic goals for pain AND function	☐ Consequences of lost medication	☐ Consequences of obtaining controlled substances from other prescribers	☐ Member using ONE pharmacy				
Will member be advised of harm AND benefit before treatment AND periodically during treatment (increased risks of respiratory depression, combination use BNZ, risks to others in household, cognitive limitations AND side effects)?	☐ Yes	☐ No						

Will treatment be prescribed at lowest effective dose?	☐ Yes	☐ No	Will treatment be reviewed within 1 - 4 weeks of starting therapy AND with any dose escalation AND re-evaluated every 3 months?	☐ Yes	☐ No	
Was there review of state's PMD/PDMP for controlled substances, with focus on opioid doses OR dangerous combinations?				☐ Yes	☐ No	
Was UDS reviewed prior to starting treatment?	☐ Yes	☐ No	Were results of UDS consistent with prescribed controlled substances?	☐ Yes	☐ No	
Is there evidence of substance use disorder?	☐ Yes	☐ No	Was evidence-based treatment arranged (for example MAT)?	☐ Yes	☐ No	☐ N/A
Is request for FEMALE of reproductive age?	☐ Yes	☐ No	Was counseling provided about opioid use during pregnancy AND about NAS?	☐ Yes	☐ No	☐ N/A

Additional Clinical Criteria

☐ **Long Acting Opioids**

Will member exceed 90 MME per day limit?	☐ Yes	☐ No	Was documentation submitted to support exceeding recommended limit?	☐ Yes	☐ No	☐ N/A

Was pain specialist consulted?	☐ Yes	☐ No	☐ N/A	Is request for chronic pain?	☐ Yes	☐ No
Was treatment initiated with IR opioid for at least TWO weeks prior to considering ER/LA opioid?					☐ Yes	☐ No
Is request for Butrans patch?	☐ Yes	☐ No		Is there documented need for opioid with lower risk for abuse AND noted concern that member, or member's household is at risk for abuse and diversion?	☐ Yes	☐ No
Is request for non-formulary agent?	☐ Yes	☐ No		Was there inadequate response OR intolerance to ALL formulary LA opioids for 2 weeks?	☐ Yes	☐ No
Is request for abuse-deterrent product?	☐ Yes	☐ No		Is there documentation of trial and failure of Butrans patch for at least 2 weeks?	☐ Yes	☐ No
				Is there documentation to indicate NEED for abuse deterrent product AND concern that member OR member's household is at risk?		
Is request for methadone?	☐ Yes	☐ No		Is female member pregnant?	☐ Yes	☐ No ☐ N/A

☐ **Short Acting Opioids**

Will member exceed 90 MME per day limit?	☐ Yes	☐ No	Was there documentation to support medical necessity of exceeding recommended MME OR day supply limit?	☐ Yes	☐ No	☐ N/A
Is request for non-formulary short-acting agent?	☐ Yes	☐ No	Was there inadequate response OR intolerance to ALL formulary short-acting opioids?	☐ Yes	☐ No	
Was documentation submitted supporting continued use of short acting agent beyond 30 days AND when used in combination with long-acting agent?				☐ Yes	☐ No	

☐ **Acute Pain - Pediatric Members <18 Years of Age**

Is request for acute pain (post-dental procedure?	☐ Yes	☐ No	Was pain assessment completed?	☐ Yes	☐ No	
Has member AND their parent/guardian been screened for previous AND current opioid use?				☐ Yes	☐ No	
Did provider check state's PMD/PDMP for controlled substances with focus on opioid doses AND dangerous combinations?	☐ Yes	☐ No	Was concomitant use with BNZ addressed, IF present?	☐ Yes	☐ No	☐ N/A
Will opioid therapy be used in COMBO with APAP and NSAIDs, unless contraindication is present for use of both?	☐ Yes	☐ No	Was COMBO therapy with APAP and NSAIDs tried AND failed OR were there contraindications present for use of both?	☐ Yes	☐ No	
Is request for codeine OR tramadol?	☐ Yes	☐ No	Is member <12 years of age?	☐ Yes	☐ No	
Is prescription limited to 8 – 12 tablets	☐ Yes	☐ No				
Will IR opioids be prescribed at lowest effective dose AND not greater than expected pain duration? (NOTE: ≤3 days is recommended by CDC. >7 days will rarely be required)				☐ Yes	☐ No	

☐ **Renewal ONLY**

Was there sustained improvement in Pain OR Function?	☐ Yes	☐ No	Was tapering plan initiated to D/C treatment of current medication?	☐ Yes	☐ No	☐ N/A
Was UDS performed in past year?				☐ Yes	☐ No	

State's PMP was reviewed AND verified (check that apply):	☐ Prescriptions from other providers	☐ Benzodiazepines	☐ ER / LA use for acute pain	☐ UDS consistent with prescribed controlled substances

Is dose ≥50 MME per day?	☐ Yes	☐ No	Did provider offer Naloxone to member?	☐ Yes	☐ No	☐ N/A

Is dose ≥90 MME per day?	☐ Yes	☐ No	Did provider refer member to Pain Specialist?	☐ Yes	☐ No	☐ N/A
Is there continued concomitant use of opioid AND benzodiazepine?	☐ Yes	☐ No	Was member counseled on FDA BBW dangers of concomitant use AND provider will prescribe at LOWEST effective dose AND duration?	☐ Yes	☐ No	☐ N/A

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.