10181 Scripps Gateway Court
San Diego, CA 92131

MedImpact

Phone: (800) 788-2949
Fax: (858) 790-7100

Opioid Edit Prior Authorization Request Form

➢ This form **cannot** be used for patients that are restricted to a specific opioid prescriber AND/OR pharmacy

Patient Information			Prescriber Information		
Patient Name:			Prescriber Name:		
Member ID#			DEA#	NPI#	
Address:			Address:		
City:		State	City:		State:
Home Phone:		Zip:	Office Phone:	Office Fax:	Zip:
Sex (circle): M F	DOB:		Contact Person:		

Diagnosis and Medical Information			
Medication:	Directions for use: (Frequency & Strength):		
☐ New Prescription OR Date Therapy Initiated:	Expected Length of Therapy: Route of Administration:		Qty: Qty per month:
Height/Weight:	Drug Allergies:	Diagnosis Code (ICD-10):	
MD Specialty:	**Prescriber's Signature:**		Date:

Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

Documentation of Medical Necessity:

1. Is the patient enrolled in hospice AND the requested opioid medication is being used for an indication that is unrelated to the terminal illness or condition(s)? ☐**Yes** ☐**No**
2. Does the patient have a diagnosis of active cancer, is receiving palliative/ end-of-life care, or is a resident of a long-term care facility? ☐**Yes** ☐**No**

Answer only the question(s) below that apply to the patient's case:

Opioid-Naïve Day Supply Limitation: (Limiting short-acting opioids to a day's supply of ≤7 days)

3. Does the patient have a diagnosis of sickle cell disease? ☐**Yes** ☐**No**
4. Is more than a 7-day supply of a short-acting opioid intended and medically necessary? ☐**Yes** ☐**No**

Opioid Cumulative Dosing Program: (Limiting the dose of opioid to a specific morphine milligram equivalent per day)

5. Does the patient have a diagnosis of sickle cell disease? ☐**Yes** ☐**No**
6. Is the prescribed amount of opioid medication intended and medically necessary? ☐**Yes** ☐**No**

Opioid Long-acting Duplicative Therapy: (Limiting the use of more than one long-acting opioid at a time)

7. Is the prescriber aware the patient is concurrently receiving more than one long-acting opioid medication and would they like to continue with treatment? ☐**Yes** ☐**No**

Opioid-Benzodiazepine Concurrent Use: (Limiting concurrent use of an opioid and a benzodiazepine)

8. Is the prescriber aware that the patient is concurrently receiving a benzodiazepine and an opioid and would they like to continue with treatment? ☐**Yes** ☐**No**

Opioid-Buprenorphine Concurrent Use: (Limiting concurrent use of an opioid and buprenorphine for opioid dependency)

9. Is the prescriber aware that the patient is currently receiving buprenorphine or a buprenorphine-containing agent for treatment of opioid dependency and would they like to continue with treatment? ☐**Yes** ☐**No**
10. Has the patient discontinued or will they discontinue opioid dependency treatment with buprenorphine or buprenorphine-containing agents because they need to resume chronic opioid treatment? ☐**Yes** ☐**No**

☐ **REQUEST FOR EXPEDITED REVIEW [24 HOURS]**

BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA.