Print Reset

Prior Authorization Request Prescriber Fax

Opioids Immediate Release (IR) Morphine Milliequivalents (MME)

Fax this form to 800-424-3260

Prime Therapeutics Management LLC partners with CoverMyMeds to allow for the submission of electronic PA requests. **For faster coverage determinations, go to www.CoverMyMeds.com.**

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews. Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information visit primetherapeutics.com.

What is the priority level of this request?

- ☐ Standard
- ☐ Date of service (if applicable): _____
- ☐ Urgent (**Note**: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

Today's Date: _____

PATIENT INFORMATION

Patient Last Name: _____

Patient First Name: _____

Patient ID: _____ Date of Birth: _____ Patient Phone: _____

Patient Street Address: _____

City: _____ State: _____ Zip: _____

Sex: ☐ Male ☐ Female Height: _____ ☐ in. ☐ cm Weight: _____ ☐ lbs. ☐ kg

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Email: _____

Prescriber NPI: _____ DEA: _____

Prescriber Phone: _____ Prescriber Fax: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Patient's Name (Last, First): _____

DRUG INFORMATION

Drug Name: _____ Drug Form: _____

Drug Strength: _____ Dosing Frequency: _____

Length of Therapy: _____ Quantity: _____

Number of Refills: _____ Day Supply: _____

☐ New Therapy ☐ Renewal If renewal, date therapy initiated: _____

If renewal, duration of therapy (specific dates): _____ to _____

CRITERIA

Note: Please attach any additional information that should be considered with this request.

Patient's Diagnosis:

☐ Chronic cancer pain due to active malignancy

☐ Non-cancer pain

☐ Post-operative pain management following tonsillectomy and/or adenoidectomy

☐ Other (ICD Code): _____

ICD Description: _____

For all requests:

1. Is the patient currently being treated with the requested agent?
   ☐ Yes ☐ No
2. Has the patient been treated with the requested agent at the requested dose within the past 90 days?
   ☐ Yes ☐ No

   If Yes, is the patient at risk if therapy is changed?
   ☐ Yes ☐ No

   If Yes, please explain: _____
3. Is the patient concurrently taking buprenorphine or buprenorphine/naloxone agent for opioid dependence treatment?
   ☐ Yes ☐ No

   If Yes, is there information in support of opioid use with buprenorphine or buprenorphine/naloxone?
   ☐ Yes ☐ No

   If Yes, please explain: _____
4. Does the requested agent contain acetaminophen?
   ☐ Yes ☐ No

   If Yes, does the requested dose of acetaminophen exceed 4 g/day?
   ☐ Yes ☐ No

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

5. Does the requested agent contain tramadol, dihydrocodeine, or codeine?
   ☐ Yes ☐ No
6. Is the patient 18 years of age or older?
   ☐ Yes ☐ No

   If No, is the patient 12 years of age or older but < 18 years of age?
   ☐ Yes ☐ No

   If Yes, will the requested agent be used for post-operative pain management following a tonsillectomy and/or adenoidectomy?
   ☐ Yes ☐ No
7. Can the requested quantity (dose) be achieved with a lower quantity of a higher strength that does **not** exceed the program quantity limit?
   ☐ Yes ☐ No

   If No, please explain: _____
8. Is there information in support of therapy with a higher dose for the requested indication?
   ☐ Yes ☐ No

   If Yes, please provide supporting information:

   _____
9. Please list all reasons for selecting the requested medication, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, or history of adverse drug reactions to alternatives, information supporting dose exceeding FDA max, lower dose tried).

   _____
10. Please list all medications that the patient has previously tried and failed for treatment of this diagnosis. (Please specify whether the patient has tried brand-name products, generic products, or over-the-counter products).

    Medication: _____ Type: _____

    Date (from): _____ Date (to): _____

    Medication: _____ Type: _____

    Date (from): _____ Date (to): _____

    Medication: _____ Type: _____

    Date (from): _____ Date (to): _____

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

For request that exceeds 50 morphine milligram equivalent per day limit

11. Is the patient eligible for hospice **or** palliative care?
    ☐ Yes ☐ No
12. Does the patient have a diagnosis of sickle cell disease?
    ☐ Yes ☐ No
13. Is the patient undergoing treatment of non-cancer pain?
    ☐ Yes ☐ No

    If Yes, please answer the following questions:

    Is there information in support of use of immediate-release single or combination opioids at a dose greater than 50 morphine milligram equivalents (MME) per day?
    ☐ Yes ☐ No

    If Yes, please provide supporting information:

    _____

    Has a formal, consultative evaluation, which includes diagnosis and a complete medical history which includes previous and current pharmacological and non-pharmacological therapy, been conducted?
    ☐ Yes ☐ No

    Is a patient-specific pain management plan on file for the patient?
    ☐ Yes ☐ No

    Has it been determined that the opioid dosages and combinations within the patient's records in the state's prescription drug monitoring program (PDMP) do **not** indicate the patient is at high risk for overdose?
    ☐ Yes ☐ No

For request that does not exceed 50 morphine milligram equivalent per day limit:

14. Is the patient eligible for hospice **or** palliative care?
    ☐ Yes ☐ No
15. Does the patient have a diagnosis of sickle cell disease?
    ☐ Yes ☐ No
16. Is the patient undergoing treatment of non-cancer pain?
    ☐ Yes ☐ No

Patient's Name (Last, First): _____

CRITERIA (CONTINUED)

If Yes, please answer the following questions:

Has a formal, consultative evaluation, which includes diagnosis and a complete medical history which includes previous and current pharmacological and non-pharmacological therapy, been conducted?

☐ Yes ☐ No

Is a patient-specific pain management plan on file for the patient?

☐ Yes ☐ No

Has it been confirmed that the patient is not diverting controlled substances, according to the patient's records in the state's prescription drug monitoring program (PDMP), if applicable?

☐ Yes ☐ No

☐ Attachments

ATTESTATION

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group, or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber's Signature: _____ **Date:** _____

(By signature, the physician confirms the above information is accurate and verifiable by patient records.)

Please fax or mail this form to:

Prime Therapeutics Management LLC
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

Phone: 1-800-424-3312

Fax this form to 800-424-3260