Immediate-Release Opioid Prior Authorization Form

CareSource

Please Fax Form To: 866-930-0019
Date Of Request: _____

Patient Information

Member Name: _____ CareSource ID: _____
Member DOB: _____ Gender: M / F
Pharmacy: _____ Pharmacy Phone #: _____

Prescriber Information

Name: _____ NPI/DEA: _____ Specialty: _____
Address: _____
Office Contact: _____ Phone: _____ Fax: _____

Diagnosis & Required Information

- ☐ Diagnosis Code (ICD-10): _____
- ☐ Prescriber attests to INSPECT review prior to writing prescription. Date Reviewed: _____
- ☐ Prescriber attests benefits and risks of opioid therapy have been discussed with patient.
- ☐ Prescriber attests patient's documented treatment plan includes pain and function scores, a baseline urine drug test, plans for random urine drug screens, and an opioid contract.
- ☐ Prescriber attests to periodic assessment of patient's outcomes (including adherence, progress notes documenting pain and function scores, random urine drug screens, no serious adverse outcomes) to ensure that continued therapy outweighs risk to patient safety.
- ☐ Prescriber attests to reassessment of patient's addiction risk or mental health concerns (e.g., using Screening, Brief Intervention, and Referral to Treatment [SBIRT] tools), including referral to an addiction medicine specialist when appropriate.
- ☐ If the patient is taking a benzodiazepine, prescriber affirms to assessment to ensure benefit outweighs the risk of benzodiazepine use along with the opioid analgesic.
- ☐ Prescriber attests member has tried and failed at least two preferred non-opioid analgesics (NSAIDs, APAP, anticonvulsants, antidepressants) at maximally tolerated doses unless all contraindicated. Please list drugs that have been tried and/or explanation of contraindication.

Medication Name	Date Started	Trial Length	Reason For Discontinuation/Contraindication

Immediate-Release Opioid Requested

Drug Name:		Strength:
Quantity:	SIG:	Dosage Form:

If member is currently treated on this medication, please list start date:

Which limits you are requesting to exceed? (Circle all that apply)

>14 Day Supply Within 45 Days	> 7 Day Supply for this Fill	>90 Days of Therapy	> 60 MED Per Script (MED= Morphine Equivalent Dose)

Reason for Request:

Physician Signature: _____ Date: _____