Extended-Release Opioid Prior Authorization Form

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 reviewing the Ohio Automated Rx Reporting System (OARRS) within 7 days prior to initiating therapy/writing prescription. Date: ______________________________

Documented in chart notes: Failure to both non-opioid pharmacologic and non-pharmacologic treatment options. Indicate treatment(s), medication(s)

___ NSAID ___ Aspirin ___Tylenol ___ Lidocaine ___Steroid ___Physical or Behavior Therapy ___Acupuncture

Documented in chart notes: Patient-specific treatment plan including risk assessment, substance abuse history, and concurrent therapies.

______ Yes _______ No

Prescriber submits baseline urine drug test and treatment plan includes requirement for random urine drug screens. (Please attach)

Documented in chart notes: Pain and function scores associated with each visit to ensure benefits of continued therapy outweighs the risk to patient safety. ______Yes _______No

Prescriber submits opioid contract with prior authorization form and attests contract is in place. (Please attach)

If members daily opioid dose exceeds 80 MED, prescriber attests to being a pain specialist or anesthesiologist, or prescribing in consultation with a pain specialist or anesthesiologist. ______ Yes _____ No

Member has tried a short-acting opioid for at least the last 60 days. LIST DRUGS IN BOX BELOW:

Medication name & strength	**Date started**	**Dose per day**	**Reason for discontinuation/contraindication**

Extended-Release Opioid Requested

Drug Name: Strength:

Quantity: SIG: Dosage Form:

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

Physician Signature:____**Date:**____________

OH-P-1423a
Effective: 06/01/2020