RxAdvance

SHORT ACTING OPIOIDS PRIOR AUTHORIZATION REQUEST

Please send the completed Prior Authorization form and any additional information to RxAdvance by fax to:
508-452-0076 for standard requests
508-452-6421 for expedited requests

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested prior authorization(s). Attach additional sheets to this form if necessary. An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures.

Patient Information	
Patient Name	
Patient Health Plan	
Patient Member ID #	
Patient Date of Birth	
Patient Phone #	

Prescriber Information	
Prescriber Name	
Prescriber Address	
Prescriber Phone #	
Prescriber Fax #	
Prescriber Specialty	
Prescriber DEA #	
Prescriber NPI #	

Drug & Medical Information	
Requested Drug(s) & Strength(s)	
Quantity(ies)	
Days Supply	
Expected Duration of Therapy	
Directions	
Diagnosis & Diagnosis Code(s) (ICD-10 Standard Codes)	
Drugs Used Previously to Treat the Same Condition	
Additional Clinical Information or History Please include any relevant test results and/or medical record notes	

Please answer the following questions if the requested drug is for **short-term treatment***:

**Short-term treatment means:*

- *If patient's age is 18 years of age or older, the requested day supply per prescription fill is 5 days or less AND the day supply in a 60-day period is 20 days or less.*
- *If patient's age is less than 18 years, the requested day supply per prescription fill is 3 days or less AND the day supply in a 60-day period is 12 days or less.*

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1. Total opioid dose (morphine milligram equivalents (MME) per day) requested is (select one):
   - ◯ 90 MME or less per day and patient is opioid-naïve (no opioid use within the past 130 days)
   - ◯ Greater than 90 MME per day and patient is opioid-naïve (no opioid use within the past 130 days). Additionally, please answer the following questions:
     a. Please specify the requested MME per day: _____
     b. Can you provide documentation of treatment plan/pain contract?
        - ◯ Yes (please attach documentation)
        - ◯ No (please attach the rationale)
     c. Prescriber has assessed the appropriateness of naloxone
        - ◯ Yes
        - ◯ No (please provide the date if you plan to do this before patient starts to take the requested drug: ___/___/_____)
   - ◯ 120 MME or less per day and patient has taken at least one opioid-containing drug in the past 130 days
   - ◯ Greater than 120 MME per day and patient has taken at least one opioid-containing drug in the past 130 days. If this one is selected, please answer the following questions:
     a. Please specify the requested MME per day: _____
     b. Can you provide documentation of treatment plan/pain contract?
        - ◯ Yes (please attach documentation)
        - ◯ No (please attach the rationale)
     c. Prescriber has assessed the appropriateness of naloxone
        - ◯ Yes
        - ◯ No (please provide the date if you plan to do this before patient starts to take the requested drug: ___/___/_____)

Please answer the following questions if the requested drug is for **long-term treatment** or if the requested day supply does not meet the definition of short-term treatment:

1. Patient meets at least one of the following:
   - ☐ Patient has a diagnosis of cancer
   - ☐ Patient is in hospice program or palliative care
   - ☐ Patient has chronic pain but does not have a cancer diagnosis. If this one is selected, please indicate if patient meets any of the additional criteria mentioned below:
     - ☐ Non-opioid therapies (e.g., non-opioid drugs [e.g., nonsteroidal anti-inflammatory drugs {NSAIDs}, tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors {SNRIs}, anticonvulsants], exercise therapy, weight loss, cognitive behavioral therapy) have been optimized and are being used in conjunction with opioid therapy. Please specify what non-opioid therapies have been tried and the dose of these therapies:

       _____

       _____

     - ☐ Has the patient's history of controlled substance prescriptions been checked using the state prescription drug monitoring program (PDMP)?
       - ◯ Yes, patient's history has been checked using the state prescription drug monitoring program (PDMP).

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- ○ No, PDMP is unavailable in state.
- ☐ Risks (e.g., addiction, overdose) and realistic benefits of opioid therapy have been discussed with the patient

2. Total opioid dose (morphine milligram equivalents (MME) per day) requested is (select one):
   - ○ 90 MME or less per day and patient is opioid-naïve (no opioid use within the past 130 days)
   - ○ Greater than 90 MME per day and patient is opioid-naïve (no opioid use within the past 130 days). Additionally, please answer the following questions:
     a. Please specify the requested MME per day: _____
     b. Can you provide documentation of treatment plan/pain contract?
        - ○ Yes (please attach documentation)
        - ○ No (please attach the rationale)
     c. Prescriber has assessed the appropriateness of naloxone
        - ○ Yes
        - ○ No (please provide the date if you plan to do this before patient starts to take the requested drug: ___/___/_____)
   - ○ 120 MME or less per day and patient has taken at least one opioid-containing drug in the past 130 days
   - ○ Greater than 120 MME per day and patient has taken at least one opioid-containing drug in the past 130 days. If this one is selected, please answer the following questions:
     a. Please specify the requested MME per day: _____
     b. Can you provide documentation of treatment plan/pain contract?
        - ○ Yes (please attach documentation)
        - ○ No (please attach the rationale)
     c. Prescriber has assessed the appropriateness of naloxone
        - ○ Yes
        - ○ No (please provide the date if you plan to do this before patient starts to take the requested drug: ___/___/_____)

Please answer the following questions if the requested drug is a **transmucosal immediate release fentanyl**:

1. Patient meets one of the following:
   - ☐ Patient is being treated for cancer-related break-through pain and/or is in hospice/palliative care setting.
   - ☐ Patient has received transmucosal immediate release fentanyl within the past 60 days.
2. Total opioid dose (morphine milligram equivalents (MME) per day) requested is (select one):
   - ○ 90 MME or less per day and patient is opioid-naïve (no opioid use within the past 130 days)
   - ○ Greater than 90 MME per day and patient is opioid-naïve (no opioid use within the past 130 days). If this one is selected, please answer the following questions:
     a. Please specify the requested MME per day: _____
     b. Can you provide documentation of treatment plan/pain contract?
        - ○ Yes (please attach documentation)
        - ○ No (please attach the rationale)
     c. Prescriber has assessed the appropriateness of naloxone
        - ○ Yes

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- ○ No (please provide the date if you plan to do this before patient starts to take the requested drug: ___/___/_____)

○ 120 MME or less per day and patient has taken at least one opioid-containing drug in the past 130 days

○ Greater than 120 MME per day and patient has taken at least one opioid-containing drug in the past 130 days. If this one is selected, please answer the following questions:

a. Please specify the requested MME per day: _____

b. Can you provide documentation of treatment plan/pain contract?
   - ○ Yes (please attach documentation)
   - ○ No (please attach the rationale)

_____

_____

c. Prescriber has assessed the appropriateness of naloxone
   - ○ Yes
   - ○ No (please provide the date if you plan to do this before patient starts to take the requested drug: ___/___/_____)

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 designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.*	
Signature of Prescriber or Authorized Representative	Date (MM/DD/YYYY)
Print Prescriber or Authorized Representative Name	