



# REQUEST FOR PRIOR AUTHORIZATION OPIOID

Prescribing Physician:	
Name (First, Last)	
Direct Phone #	
Fax #	
Physician specialty	

Patient:	
Name (First, Last)	
ID #	
Phone #	Client
Birth Date _ / _ / _	Sex M <input type="checkbox"/> F <input type="checkbox"/>

Name and title of person completing form (please print)			
Drug name:	Strength:	Length of Therapy:	Quantity Requested:
Has patient been on this drug and, if yes, for how long at this dosage?			
Patient's diagnosis requiring the use of this medication:			
Please list the non-opioid therapies (e.g. NSAIDs, physical therapy) the member has tried or failed:			
Name of medication/therapy	Reason for failure	Date	
		_ / _ / _	
		_ / _ / _	
		_ / _ / _	
Does the patient have an opioid agreement with the prescriber? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please attach agreement.			
Is a controlled substance report requested and reviewed with each prescription written? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, has the report revealed overcompliance or controlled prescription unknown to the prescriber? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Is the patient subject to random drug screens? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide report. Have drug screens been consistent with treatment plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please explain findings.			
Is the patient subject to random pill counts? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, have pill counts been consistent with treatment plan? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please explain findings.			
What is the treatment plan to reduce opioid use or to prevent escalation of use? Please attach chart notes.			
Other Information:			

Physician's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Fax Request and Supporting Documentation to:

**SGRX @ 313-264-0985**

For ScriptGuideRX use only)

Date faxed: ____/____/____
Date received: ____/____/____
Date completed: __/____

Decision (all authorizations are pending valid eligibility)
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