PRIOR AUTHORIZATION REQUEST
OPIOIDS

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

Patient:	
Name (First, Last)	
ID #	Sex (at birth): ❑ M ❑ F
Phone #	Client
Birth Date: ___/___/___	Age

Name and title of person completing form (please print):				
Drug name:	**Dose/Strength:**	**Frequency:**	**Length of Therapy:**	**Quantity Requested:**

1. Has patient been on this drug and, if yes, for how long at this dosage? Yes ❑ No ❑

2. Patient's diagnosis & ICD code requiring the use of this medication:

3. Please list other concurrent opioid therapies the member is currently taking:

4. Please list the non-opioid therapies (e.g. NSAIDs, physical therapy) the member has tried or failed below

Drug name	Reason for failure	Dates
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___

5. Does the patient have an active signed pain contract within 3 years? Yes ❑ No ❑

6. Is a controlled substance report requested and reviewed with each prescription? Yes ❑ No ❑

Date of last review: _____

7. Has the patient completed annual compliant drug screenings? Yes ❑ No ❑

8. Does the patient have any opioid violations? Yes ❑ No ❑
If yes, please explain: _____

9. Is the patient periodically re-evaluated for possible use de-escalation when appropriate? Yes ❑ No ❑

10.Have you attached chart notes within 3 months (new initiations) or 12 months (renewals)? Yes ❑ No ❑

11. Please calculate the total daily Morphine Milligram Equivalents (MME):

Physician's Name (print): _____ **Title:** _____

Physician's Signature: _____ **Date:** ___/___/_____

Fax PA request form AND Supporting Documentation to: SGRX @ 313-264-0985