PRIOR AUTHORIZATION REQUEST OPIOIDS

Prescribing Physician:
Name (First, Last)
Direct Phone #
Fax #
Physician specialty ❑ Pain Management ❑ Other:________________

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

Name and title of person completing form (please print):				
1. Drug name:	2. Dose/Strength:	3. Frequency:	4. Quantity Requested:	5. Length of Therapy:
6. Has patient been on this drug? ❑Yes ❑No If yes, for how long: ______________________				
7. Diagnosis:	8. ICD code:			

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

Name of medication/therapy	Reason for failure	Dates
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___
		From ___/___/___ To ___/___/___

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

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

Date of last review: ________________

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

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

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

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

Other information:

Physician's Name (print): ______________________________ Title: ______________

Physician's Signature: ________________________________Date: ___/____/________

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