PRIOR AUTHORIZATION REQUEST OPIOIDS

Prescribing Physician	
Name (First, Last)	
Physician Specialty ☐ Pain Management ☐ Other:	
Phone #	Fax #

Prescribing Physician	
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. Length of Therapy:	5. Quantity Requested:

6. Has patient been on this drug? ☐ Yes ☐ If yes, for how long:	7. Diagnosis:	8. ICD code:

9. Please list other concurrent opiod therapies the member is currently taking:

10. 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

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

12. Is a controlled substance report requested and reviewed with each prescription? ☐ Yes ☐ No

Date of last review:

13. Has the patient completed annual compliant drug screenings? ☐ Yes ☐ No

14. Does the patient have any opioid violations? ☐ Yes ☐ No

If yes, please explain:

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

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

17. 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