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 ☐ F ☐

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 ☐ No ☐ If yes, please attach agreement.

Is a controlled substance report requested and reviewed with each prescription written? Yes ❑ No ❑
If yes, has the report revealed overcompliance or controlled prescription unknown to the prescriber?
Yes ❑ No ❑

Is the patient subject to random drug screens? Yes ❑ No ❑
If yes, please provide report. Have drug screens been consistent with treatment plan? Yes ❑ No ❑
If no, please explain findings.

Is the patient subject to random pill counts? Yes ❑ No ❑
If yes, have pill counts been consistent with treatment plan? Yes ❑ No ❑
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**___/___/_____

Office Visit Chart Notes are required for the review

Fax to: SGRX @ 313-264-0985

For ScriptGuideRX use only)

Date faxed: ___/___/___
Date received: ___/___/___
Date completed: ___/___/___

Decision (all authorizations are pending valid eligibility)