



## Oxymorphone extended-release (ER) Long-Acting Opioid Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<p><b>For states, such as GA and AR, that have a terminal illness mandate, and for patients who have a terminal illness, please answer the following:</b></p> <p>Will the requested medication be used for the treatment of a terminal condition or associated symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "YES", please indicate the patient's estimated life expectancy:</p> <p><input type="checkbox"/> Less than 6 months    <input type="checkbox"/> Less than 24 months    <input type="checkbox"/> Less than ____ months (please specify)</p>					
<p><b>Continuation of therapy:</b></p> <p>Is the patient established on the prescribed medication and this prescription is for continuation of therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p><b>Select all the applicable diagnoses below:</b></p> <p><input type="checkbox"/> Cancer pain</p> <p><input type="checkbox"/> Moderate to severe chronic pain that is non-neuropathic</p> <p><input type="checkbox"/> Moderate to severe neuropathic pain or fibromyalgia</p> <p><input type="checkbox"/> Other diagnosis: _____ <input type="checkbox"/> ICD-10 Code(s): _____</p>					
<p><b>End of life care:</b></p> <p>Is the patient receiving opioids as part of end of life care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p><b>For diagnosis of moderate to severe chronic pain that is non-neuropathic, please answer the following:</b></p> <p>Is the prescribed medication being used as an as-needed (PRN) analgesic? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the prescribed medication being used for pain that is mild or not expected to persist for an extended period of time? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the prescribed medication being used for acute pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the prescribed medication being used for postoperative pain? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer the following:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Has the patient already received chronic opioid therapy prior to surgery or is the postoperative pain expected to be moderate to severe and persist for an extended period of time? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <p>Is the patient filling the prescribed medication for the first time? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prior to the start of therapy with the prescribed medication, has the patient failed an adequate trial of a short-acting opioid? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please document the name of the medication(s), dose, date, and duration of trial:</p> <p>Medication: _____ Dose: _____ Date of trial: _____ Duration of trial: _____</p>					

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**For diagnosis of moderate to severe neuropathic pain or fibromyalgia, please answer the following:**

Does the patient have a contraindication to or has not exhibited an adequate response to treatment with gabapentin titrated to a therapeutic dose?  Yes  No If **yes**, please document dose, date, and duration of trial:

Dose: \_\_\_\_\_ Date of trial: \_\_\_\_\_ Duration of trial: \_\_\_\_\_

Does the patient have a contraindication to or has not exhibited an adequate response to treatment with a tricyclic antidepressant titrated to a therapeutic dose?  Yes  No If **yes**, please document the name of the medication(s), dose, date, and duration of trial:

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Date of trial: \_\_\_\_\_ Duration of trial: \_\_\_\_\_

Is the patient filling the prescribed medication for the first time?  Yes  No

Prior to the start of therapy with the prescribed medication, has the patient failed an adequate trial of a short-acting opioid?  Yes  No

If **yes**, please document the name of the medication(s), dose, date, and duration of trial:

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Date of trial: \_\_\_\_\_ Duration of trial: \_\_\_\_\_

**Reauthorization [Non-cancer and non-end of life care only]:**

**If this is a reauthorization request, please answer all of the following questions:**

1. What are the treatment goals for this patient? (Document treatment goals and estimated duration of treatment) \_\_\_\_\_
2. Does the treatment plan include the use of a non-opioid analgesic and/or non-pharmacologic intervention?  Yes  No
3. Has the patient demonstrated meaningful improvement in pain and function using a validated instrument (e.g., Brief Pain Inventory)?  Yes  No
4. Has the patient been screened for substance abuse/opioid dependence using a validated instrument (e.g., DAST-10)?  Yes  No
5. What is the rationale for not tapering and discontinuing the requested medication? (Document rationale) \_\_\_\_\_
6. Has the patient been screened for comorbid mental health conditions?  Yes  No
7. Is there a state prescription drug monitoring program (PDMP) available?  Yes  No  
If **yes**, has the prescriber identified that there are NO concurrently prescribed controlled substances from the PDMP?  Yes  No
8. Does the prescriber acknowledge that he/she has completed an assessment of increased risk for respiratory depression in patients who have medical comorbidities or are using concurrent benzodiazepine/other drugs that could potentially cause drug-drug interactions?  Yes  No
9. What is the patient's total daily morphine equivalent dose? \_\_\_\_\_

**Quantity limit requests:**

What is the quantity requested per DAY? \_\_\_\_\_

Does the patient's diagnosis include malignant (cancer) pain?  Yes  No

Was the requested medication prescribed by a pain specialist or by pain management consultation?  Yes  No

**Select all of the following that have been maintained and documented in chart notes\*:**

- A description of the nature and intensity of the pain
- An appropriate patient medical history and physical examination
- An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
- Appropriate dose escalation
- Ongoing, periodic review of the course of opioid therapy
- Verification that the risks and benefits of the use of the requested medication have been discussed with the patient, significant other(s), and/or guardian

**\*Chart documentation:**

Will chart documentation be submitted with this form, confirming the above information?  Yes  No

**\*\*Please note: Chart documentation of the above is required to be submitted along with this fax form.**

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

Please note: This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-800-527-0531.