Prior Authorization Request

EOC: Long Acting Opioids

Serve You Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Fill out electronically, or print using blue or black ink. If you have questions or need additional forms, visit ServeYouRx.com or call 800-759-3203.

Fax completed form to: 800-480-4840, Attn: Authorizations **Note:** Blank fields or illegible responses may delay the review process.

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Member ID #: _____ Group #: _____

Permanent Address: _____ City: _____ State: _____ ZIP: _____

Primary Phone #: _____ ☐ Mobile ☐ Work ☐ Home

Secondary Phone #: _____ ☐ Mobile ☐ Work ☐ Home

PRESCRIBER INFORMATION

Name: _____ Specialty: _____

Address: _____ City: _____ State: _____ ZIP: _____

NPI: _____ State License ID: _____

Office Contact: _____ Fax: _____ Phone: _____

REQUESTED MEDICATION

Drug Name: _____ Strength: _____ Frequency: _____

Directions: _____

Expected Duration of Therapy: _____ If this is a continuation of therapy, provide start date: _____

☐ **Pertinent medical history or information for this patient is attached that may support approval**

☐ **Urgent review requested**

REQUIRED INFORMATION

1 Please indicate if this request is for:
☐ New Start ☐ Continuation of Therapy

2 Diagnosis for use: _____

3 Duration of therapy: _____

4 Is the patient being treated for cancer related pain or pain associated with end of life?
☐ Yes (Please answer questions #5 and #6, if applicable; no other questions need to be answered.)
☐ No

5 For requests for Arymo ER, brand Kadian, Morphabond ER, Nucynta ER, Xtampza ER, or Zohydro ER, does the patient have a history of failure, contraindication, or intolerance to at least two of the following medications listed below:
☐ Yes ☐ No

6 **If yes to above:** Please indicate which medications the patient has tried and failed:
☐ Generic hydromorphone ER
☐ Generic oxymorphone ER
☐ Generic morphine sulfate ER
☐ Embeda
☐ Hysingla ER
☐ Oxycontin

7 Has the patient tried and failed an adequate (minimum of 4 week) trial of a short-acting opioid?
☐ Yes ☐ No

8 For NON-NEUROPATHIC PAIN, is the medication being used for any of the following (see Question #9 below)?
☐ Yes ☐ No

9 **If yes to above:** Please indicate if any of the following apply:
☐ For use as an as-needed PRN analgesic
☐ For pain that is mild or not expected to persist for an extended period of time
☐ For acute pain

10 For POSTOPERATIVE PAIN, do either of the following apply? (see below) ☐ Yes ☐ No ☐ NA

11 **If yes to above:** Please indicate which of the following apply:
☐ Patient was already receiving chronic opioid therapy prior to surgery
☐ Postoperative pain is expected to be moderate to severe and persist for an extended period of time

12 For NEUROPATHIC PAIN, has the patient exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose?
☐ Yes ☐ No

ServeYou Rx

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Patient Last Name: _____ First Name: _____ MI: _____

13 For NEUROPATHIC PAIN, has the patient exhibited an adequate response to at least 6-8 weeks of treatment with a tricyclic antidepressant titrated to a therapeutic dose?

☐ Yes ☐ No

14 For continuation of therapy, is documentation available that addresses **ALL** of the following? (please provide such documentation)

☐ Yes ☐ No

15 **Please indicate which of the following apply, and provide documentation for each:**

- ☐ Treatment goals and estimated duration of treatment
- ☐ Treatment plan including use of nonopioid analgesics and/or nonpharmacologic intervention
- ☐ Evidence that the patient has demonstrated meaningful improvement in pain and function using a validated instrument
- ☐ Evidence that the patient has been screened for substance abuse/opioid dependence using a validated instrument
- ☐ Evidence that the patient has been screened for comorbid mental health conditions
- ☐ An assessment of increased risk for respiratory depression, if applicable based on medical comorbidities and/or drug-drug interactions (e.g. benzodiazepines)
- ☐ Total daily morphine equivalent dose
- ☐ Rationale for not tapering or discontinuing the opioid

16 Additional comments:

_____ _____

Prescriber Signature Date

Certain prescription benefit plans or situations may require additional information or clarification to evaluate a prior authorization request. For complete details about benefits, limitations, conditions and exclusions, please refer to the applicable plan.