Prior Authorization Request

EOC: Short 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 #: ______________ Secondary Phone #: ______________

☐ Mobile ☐ Work ☐ Home ☐ 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 what best describes the patient's history of opioid therapy:
- ☐ New to Therapy
- ☐ Treatment-Experienced (defined as having received an opioid prescription within the previous 120 days)

2 Is the patient receiving opioids for the management of cancer-related pain? (If yes, no need to answer any additional questions.) ☐ Yes ☐ No

3 Is the patient receiving opioids as part of end-of-life care (ie, hospice)? (If yes, no need to answer any additional questions.) ☐ Yes ☐ No

4 Diagnosis for use: ______________

5 Duration of therapy: ______________

6 Is the medication prescribed by or in consultation with a pain specialist?
☐ Yes ☐ No

7 Is an active treatment plan in place for the patient that includes but is not limited to a specific treatment objective and the use of other pharmacological and non-pharmacological agents for pain relief, as appropriate? ☐ Yes ☐ No

8 **If yes:** Describe the treatment plan:

____

9 Has the patient signed an informed consent document and has an addiction risk assessment been performed? ☐ Yes ☐ No

10 Has an agreement been written/ signed between the prescriber and patient that addresses the issues of prescription management, diversion, and the use of other substances?
☐ Yes ☐ No

11 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.

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