Print Reset

sunshine health

**MEDICATION PRIOR AUTHORIZATION REQUEST FORM**
**FAX this completed form to 1-833-546-1507**
OR Mail request to: Pharmacy Services PA Dept.
| 5 River Park Place East, Suite 210 | Fresno, CA 93720
Call 1-866-399-0928 to request a 72-hour supply of medication.
Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, except during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

# OPIOID AGENTS

**LENGTH OF APPROVAL: UP TO 3 MONTHS**
**Note: Form must be completed in full. An incomplete form may be returned.**

**Recipient's Full Name:**

**Recipient's Medicaid ID#:**

**Date of Birth (MM/DD/YYYY):** / /

**Prescriber's Full Name:**

**Prescriber's NPI:**

**Prescriber Phone Number:** - -

**Prescriber Fax Number:** - -

☐ **Short-Acting Opioid** ☐ **Long-Acting Opioid** ☐ **Both**

**Drug Name:** _____

**Drug Strength:** _____

**Dose:** _____

**Directions:** _____

**Diagnosis**: _____

**Prescriber's Specialty (or consultation with a specialist):** _____

1. There was a trial and failure of the following medication(s) prior to prescribing short-acting opioids (check all that apply):
   ☐ Baclofen ☐ NSAIDs (oral) ☐ Tricyclic antidepressant (e.g., amitriptyline)
   ☐ Lyrica ☐ Duloxetine ☐ Other: _____
   - Any requests for post-operative, short-acting opioids cannot exceed a 7-day supply without medical justification.
   - Long-acting opioids are indicated for patients with chronic, moderate to severe pain who require around-the-clock opioid analgesics. Supporting documentation of a minimum two-month trial of short-acting opioid use is required.
2. If the request is for a non-preferred agent, trial and failure of preferred agents is required. Medical records documenting trials are also required. **List the names of the medications, strength, frequency, length of trials, and rationale for discontinuation**.
3. What is the daily morphine milligram equivalent (MME) of the prescribed medication(s)? _____
   - If patient is treatment-naïve (MME exceeding 90), PA will not be approved.

*(Form continued on next page.)*

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**Recipient's Full Name**

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
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4. Did the prescriber review the **Prescribed Drug Monitoring Program** prior to prescribing this opioid medication as required by Florida statute?

   ☐ Yes ☐ No

   a. If NO, explain why: _____

   - Submission of a signed patient-prescriber pain management, opioid treatment agreement is required for chronic pain patients

5. When is the next office visit scheduled for the patient with chronic pain? Date: _____

6. Has the prescriber ordered and reviewed a urine drug screen (UDS) for new chronic pain patients prior to initiation of opioid therapy? (Submission of a UDS within the past 90 days is required.)

   ☐ Yes ☐ No

   a. If NO, explain why: _____

## Continuation of Ongoing Therapy

1. Has the prescriber ordered and reviewed a UDS for patients with chronic pain to ensure compliance of opioid therapy? (Submission of a UDS within the past 90 days is required.)

   ☐ Yes ☐ No

2. When is the next office visit scheduled for the patient with chronic pain? Date: _____

3. If requesting an increase in dose or frequency, calculate the new daily morphine milligram equivalent (MME) of the prescribed medication(s) and provide rationale for why this dose is medically necessary.

****Clinicians should consider offering naloxone to patients with an increased risk of opioid overdose.****

***I certify that the benefits of opioid treatment for this patient outweigh the risk of treatment.***

**Prescriber's Signature:** _____ **Date:** _____

**REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes) and the most recent copies of related labs. The provider must retain copies of all documentation for five years.**