MEDICATION PRIOR AUTHORIZATION REQUEST FORM

FAX this completed form to 1-888-865-6531

OR Mail request to: Envolve Pharmacy Solutions PA Dept. | 5 River Park Place East, Suite 210 | Fresno, CA 93720

Call 1-833-705-1351 to request a 72-hour supply of medication.

Envolve Pharmacy Solutions 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.

Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

OPIOID AGENTS

LENGTH OF APPROVAL: UP TO 3 MONTHS

Note: Form must be completed in full. An incomplete form may be returned.

envolve Pharmacy Solutions

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number ___ - ___ - ____

Prescriber Fax Number ___ - ___ - ____

☐ **SHORT-ACTING OPIOID** ☐ **LONG-ACTING OPIOID** ☐ **BOTH (check all that apply)**

Drug, Dose and Directions: _____

_____

Diagnosis: _____

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

1. Trial and failure of other medications prior to prescribing short-acting opioids **(check all that apply):**
   - ☐ Baclofen
   - ☐ NSAIDS (oral)
   - ☐ Duloxetine
   - ☐ Tricyclic Antidepressant (e.g. amitriptyline)
   - ☐ Lyrica
   - ☐ Other: _____
2. Any requests for post-operative, short-acting opioids cannot exceed a 7-day supply without medical justification.
3. Long acting opioids are indicated for chronic, moderate to severe pain who require around-the clock opioid analgesic (supporting documentation required of a minimum of a two-month trial of short-acting opioid use).
4. If the request is for a non-preferred agent, trial and failure of preferred agent(s) is required (i.e. list the name of the medication(s), strength, frequency, length of trial and rationale for discontinuation; medical records documenting trial is also required).

5. What is the daily morphine milligram equivalent (MME) of the prescribed medication(s)?

   _____. If patient is treatment naïve, MME exceeding 90, will not be approved.

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6. Did the prescriber review the Prescribed Drug Monitoring Program prior to prescribing this opioid medication as required by Florida Statute?

☐ Yes ☐ No

If *NO*, please explain why:

_____

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

8. When is the next office visit scheduled for the patient with chronic pain? _____

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

☐ Yes ☐ No

If *NO*, please explain why:

_____

Continuation of Ongoing Therapy:

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

☐ Yes ☐ No

2. When is the next office visit scheduled for the patient? _____

****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 outweighs 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.