



Long Acting Opioids

PRIOR AUTHORIZATION REQUEST FORM

For authorization, **please answer each question, include patient chart notes to document clinical information, and fax this form back to the PEHP Prior Authorization Department at (801) 245-7774** or mail to: PEHP Pharmacy services, 560 East 200 South Salt Lake City, UT 84102. If you have prior authorization questions, you may phone the PEHP Customer Service at (801) 366-7551.

1. Date:	2. Patient Name:	3. ID #:
4. D.O.B:	5. Physician:	6. Office Phone:
7. Office Fax:	8. Office Contact:	9. Dose Request:
10. Sex:	11. Weight:	

Authorization is requested from: _____ to _____

Question	Yes	No	Comments/Notes
12. Please select the medication you are requesting: <input type="checkbox"/> Kadian® (morphine sulf. ER caps) #60 capsules per 30 days <input type="checkbox"/> Exalgo® (hydromorphone ER tabs) #30 tablets per 30 days <input type="checkbox"/> Opana ER® (oxymorphone ER) #60 tablets per 30 days <input type="checkbox"/> Xtampza® ER (oxycodone ER caps) #60 capsules per 30 days <input type="checkbox"/> 24-hour morphine sulfate ER caps #30 capsules per 30 days			
13. If the quantity prescribed will exceed the above amount, indicate the medication, strength, and dosing: Medication: _____ Strength: _____ Dosage: _____			For review of this quantity limit please provide the last 6 months of chart notes.
14. Select the patient's diagnosis: <input type="checkbox"/> Chronic Moderate or Severe Pain <input type="checkbox"/> Severe Chronic Pain Associated with a Malignancy			If Severe Chronic Pain Associated with a Malignancy, skip to 20.
15. Does the patient have a history of substance abuse?			
16. Will the patient's pain management be administered solely by the prescribing provider?			Prior authorization will be locked into one provider
17. Provide the patient's total daily morphine equivalency dose (MED):		MED: _____	If the patient has a MED > 120 they will be enrolled in our mandatory pain management program.
18. Select any of the following immediate release pain therapies that the patient has tried and failed to treat their pain: <input type="checkbox"/> codeine <input type="checkbox"/> hydromorphone <input type="checkbox"/> hydrocodone <input type="checkbox"/> morphine <input type="checkbox"/> oxycodone			Verification will be made by reviewing the patient's drug history or patient chart notes.
19. Does the patient have a treatment plan with goal directed therapy?			Provide treatment plan.
20. Has the patient had an adequate 30-day trial and failure of a morphine controlled release medication; MS Contin® or morphine SR and pain is still unmanageable?			Verification will be made by reviewing the patient's drug history or patient chart notes.
21. If you are requesting a dose above what PEHP allows, are you planning to reduce the patient's total daily opioid consumption?			
22. Will the patient continue using any short acting opioid therapies?			
23. If 'yes' to 22, list ALL prescribed short acting opioids, dose, and directions:			
23. Physician's signature: _____			

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