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Prior Authorization Form

1361-M Opioids ER MME Limit and Post Limit

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of 1361-M Opioids ER MME Limit and Post Limit .

Drug Name
(specify drug) ______________________________

Quantity　　Frequency　　Strength

Route of Administration　　Expected Length of Therapy

Patient Information
Patient Name: ______________________________
Patient ID: ______________________________
Patient Group No.: ______________________________
Patient DOB: ______________________________
Patient Phone:

Prescribing Physician
Physician Name: ______________________________
Physician Phone: ______________________________
Physician Fax: ______________________________
Physician Address: ______________________________
City, State, Zip: ______________________________

Diagnosis: ______________________________ **ICD Code:** ______________________________

Comments: ______________________________

Please circle the appropriate answer for each question.

Question	Answer
1. Is the requested drug being prescribed for pain associated with cancer, a terminal condition, or pain being managed through hospice or palliative care?	Y N
[If yes, then no further questions.]	
2. Is the requested drug being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid?	Y N
3. Can the patient safely take the requested dose based on their history of opioid use?	Y N

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4.	Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder?	Y N
5.	Will the patient's pain be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety?	Y N
6.	Which drug is being requested? Please check drug being requested.	
	[Note: These drugs should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.]	
	Arymo ER (morphine extended-release tablets) (if checked, go to 18)	☐
	Avinza (morphine extended-release capsules) (if checked, go to 10)	☐
	Belbuca (buprenorphine buccal film) (if checked, go to 11)	☐
	Butrans (buprenorphine transdermal system) (if checked, go to 12)	☐
	Conzip (tramadol hydrochloride extended-release) (if checked, go to 13)	☐
	Dolophine 5 mg, 10 mg (methadone hydrochloride tablets) (if checked, go to 8)	☐
	Duragesic (fentanyl transdermal system) (if checked, go to question 14)	☐
	Embeda (morphine sulfate/naltrexone HCl extended-release) (if checked, go to question 15)	☐
	Exalgo (hydromorphone hydrochloride extended-release) (if checked, go to question 16)	☐
	Hysingla ER (hydrocodone bitartrate extended-release tablets) (if checked, go to 7)	☐
	Kadian (morphine extended-release capsules) (if checked, go to question 17)	☐
	Methadone 10 mg/mL Intensol soln (if checked, go to 8)	☐
	Methadone 5 mg/5 mL,10 mg/5 mL oral soln, 200 mg/20 mL injection (if checked, go to 8)	☐
	Methadose 5 mg, 10 mg (methadone hydrochloride tablets) (if checked, go to 8)	☐
	Morphabond (morphine extended-release tablets) (if checked, go to 18)	☐
	MS Contin (morphine extended-release tablets) (if checked, go to 18)	☐

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	Nucynta ER (tapentadol extended-release) (if checked, go to 19)	☐
	Opana ER (oxymorphone hydrochloride extended-release tablets) (if checked, go to 20)	☐
	OxyContin (oxycodone hydrochloride extended-release tablet) (if checked, go to 21)	☐
	Targiniq ER (oxycodone HCl/naloxone HCl extended-release tablets) (if checked, go to 22)	☐
	tramadol extended-release (if checked, go to 13)	☐
	Ultram ER (tramadol extended-release) (if checked, go to 13)	☐
	Vantrela ER (hydrocodone bitartrate extended-release tablets) (if checked, go to 7)	☐
	Xtampza ER (oxycodone extended-release capsules) (if checked, go to 23)	☐
	Zohydro ER (hydrocodone bitartrate extended-release capsules) (if checked, go to 7)	☐
	Troxyca ER (oxycodone/naltrexone extended-release capsules) (if checked, go to 24)	☐
7.	Does the patient require use of MORE than any of the following: A) 60 units/month of Hysingla ER 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg OR Zohydro ER 50 mg OR Vantrela ER 60 mg, 90 mg, B) 30 units/month of Hysingla ER 120 mg, C) 90 units/month of Zohydro ER 10 mg, 15 mg, 20 mg, 30 mg, 40 mg OR Vantrela ER 15 mg, 30 mg, 45 mg?	Y N
	[No further questions.]	
8.	Is the methadone product being prescribed for detoxification treatment or as part of a maintenance treatment plan for opioid/substance abuse or addiction?	Y N
9.	Does the patient require use of MORE than any of the following: A) 120 tablets/month of Dolophine or Methadose, B) 600 mL/month of Methadone oral solution (5 mg/5 mL or 10 mg/5 mL), C) 40 mL (2 multidose vials) of Methadone 200 mg/20 mL injection, D) 120 mL/month of Methadone Intensol (10 mg/mL) solution?	Y N
	[No further questions.]	
10.	Does the patient require use of MORE than 60 capsules/month of Avinza 30 mg, 45 mg, 60 mg, 75 mg, 90 mg OR 30 capsules/month of Avinza 120 mg?	Y N
	[No further questions.]	
11.	Does the patient require use of MORE than 90 films/month of Belbuca 75 mcg, 150 mcg, 300 mcg, 450 mcg OR MORE than 60 films/month of Belbuca 600 mcg, 750 mcg, 900 mcg?	Y N

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[No further questions.]	
12. Does the patient require use of MORE than 8 patches/month of Butrans 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr OR MORE than 4 patches/month of Butrans 15 mcg/hr, 20 mcg/hr?	Y N
[No further questions.]	
13. Does the patient require use of MORE than 60 units/month of Conzip 100 mg, tramadol ER 100 mg, 150 mg, or Ultram ER 100 mg, OR 30 units/month of Conzip 200 mg, 300 mg, or tramadol ER 200 mg, 300 mg, or Ultram ER 200 mg, 300 mg?	Y N
[No further questions.]	
14. Does the patient require use of MORE than 20 patches/month of Duragesic 12 mcg, 25 mcg, 37.5 mcg OR MORE than 10 patches/month of Duragesic 50 mcg, 62.5 mcg, 75 mcg, 87.5 mcg, 100 mcg?	Y N
[No further questions.]	
15. Does the patient require use of MORE than 90 capsules/month of Embeda 20/0.8 mg, 30/1.2 mg OR MORE than 60 capsules/month of Embeda 50/2 mg, 60/2.4 mg, 80/3.2 mg, 100/4 mg?	Y N
[No further questions.]	
16. Does the patient require use of MORE than 60 tablets/month of Exalgo 8 mg, 12 mg, 16 mg OR MORE than 30 tablets/month of Exalgo 32 mg?	Y N
[No further questions.]	
17. Does the patient require use of MORE than any of the following: A) 90 capsules/month of Kadian 10 mg, 20 mg, 30 mg, 40 mg, B) 60 capsules/month of Kadian 50 mg, 60 mg, 70 mg, 80 mg, 100 mg, C) 30 capsules/month of Kadian 130 mg, 150 mg, 200 mg?	Y N
[No further questions.]	
18. Does the patient require use of MORE than any of the following: A) 90 tablets/month of Arymo ER 60 mg or MorphaBond 15 mg, 30 mg or MS Contin 60 mg, B) 120 tablets/month of Arymo ER 15 mg, 30 mg or MS Contin 15 mg, 30 mg, C) 60 tablets/month of MorphaBond 60 mg, 100 mg or MS Contin 100 mg, 200 mg?	Y N
[No further questions.]	
19. Does the patient require use of MORE than 90 tablets/month of Nucynta ER 50 mg, 100 mg, 150 mg OR MORE than 60 tablets/month of Nucynta ER 200 mg, 250 mg?	Y N
[No further questions.]	

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20. Does the patient require use of MORE than 90 tablets/month of Opana ER 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, OR 60 tablets/month of Opana ER, 30 mg, 40 mg?	Y N
[No further questions.]	
21. Does the patient require use of MORE than 90 tablets/month of OxyContin 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, OR 60 tablets/month of OxyContin 60 mg, 80 mg?	Y N
[No further questions.]	
22. Does the patient require use of MORE than 90 tablets/month of Targiniq ER 10 mg/5 mg, 20 mg/10 mg OR 60 tablets/month of Targiniq ER 40 mg/20 mg?	Y N
[No further questions.]	
23. Does the patient require use of MORE than 90 capsules/month of Xtampza ER?	Y N
[No further questions.]	
24. Does the patient require use of MORE than 90 capsules/month of Troxyca ER 10 mg/1.2 mg, 20 mg/2.4 mg, 30 mg/3.6 mg, 40 mg/4.8 mg OR 60 capsules/month of Troxyca ER 60 mg/7.2 mg, 80 mg/9.6 mg?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date

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