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Prior Authorization Form

1363-M Opioids IR 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 1363-M Opioids IR 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.

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.	Can the patient safely take the requested dose based on their history of opioid use?	Y N
3.	Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder?	Y N

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4. Is the requested drug being prescribed for moderate to severe CHRONIC pain where use of an opioid analgesic is appropriate?	Y N
[Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.]	
[If no, then skip to question 6.]	
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
[If yes, then skip to question 7.]	
[If no, then no further questions.]	
6. Is the requested drug being prescribed for moderate to severe ACUTE pain where use of an opioid analgesic is appropriate?	Y N
[If yes, then skip to question 8.]	
[If no, then no further questions.]	
7. Which drug is being requested (applies to brand or generic)?	
[Note: Please check which drug (applies to brand or generic).]	
codeine sulfate oral solution or tablets (if checked, go to 9)	☐
hydromorphone oral liquid, suppositories, tablets (if checked, go to 10)	☐
levorphanol tablets (if checked, go to 11)	☐
meperidine oral solution and tablets (if checked, go to 12)	☐
morphine sulfate oral concentrate or oral solution (if checked, go to 13)	☐
morphine sulfate suppositories (if checked, go to question 14)	☐
morphine sulfate tablets (if checked, go to question 15)	☐
oxycodone, Oxaydo, or RoxyBond capsules or tablets (if checked, go to question 16)	☐
oxycodone oral concentrate or oral solution (if checked, go to 17)	☐
oxymorphone tablets (if checked, go to question 18)	☐
pentazocine/naloxone tablets (if checked, go to 19)	☐
tapentadol tablets (Nucynta) (if checked, go to 20)	☐
tramadol tablets (if checked, go to 21)	☐

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8. Which drug is being requested (applies to brand or generic)?	
[Note: Please check which drug (applies to brand or generic).]	
codeine sulfate oral solution or tablets (if checked, go to 22)	☐
hydromorphone oral liquid, suppositories, tablets (if checked, go to 23)	☐
levorphanol tablets (if checked, go to 24)	☐
meperidine oral solution and tablets (if checked, go to 25)	☐
morphine sulfate oral concentrate or oral solution (if checked, go to 26)	☐
morphine sulfate suppositories (if checked, go to question 27)	☐
morphine sulfate tablets (if checked, go to question 28)	☐
oxycodone, Oxaydo, or RoxyBond capsules or tablets (if checked, go to question 29)	☐
oxycodone oral concentrate or oral solution (if checked, go to 30)	☐
oxymorphone tablets (if checked, go to question 31)	☐
pentazocine/naloxone tablets (if checked, go to 32)	☐
tapentadol tablets (Nucynta) (if checked, go to 33)	☐
tramadol tablets (if checked, go to 34)	☐
9. Does the patient require use of MORE than 840 mL/month of codeine sulfate oral solution OR MORE than 84 tablets/month of codeine sulfate tablets?	Y N
[No further questions.]	
10. Does the patient require use of MORE than any of the following: A) 1500 mL/month of hydromorphone liquid, B) 180 hydromorphone suppositories/month, C) 270 tablets/month of hydromorphone 2 mg, D) 225 tablets/month of hydromorphone 4 mg, E) 90 tablets/month of hydromorphone 8 mg?	Y N
[No further questions.]	
11. Does the patient require use of MORE than 180 levorphanol tablets/month?	Y N
[No further questions.]	
12. Does the patient require use of MORE than 120 mL/month of meperidine oral solution OR MORE than 24 tablets/month of meperidine tablets?	Y N
[No further questions.]	

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13. Does the patient require use of MORE than 270 mL/month of morphine sulfate oral concentrate solution OR MORE than 1350 mL/month of morphine sulfate oral solution?	Y N
[No further questions.]	
14. Does the patient require use of MORE than 270 suppositories/month of morphine sulfate suppository 5 mg, 10 mg, 20 mg OR MORE than 180 suppositories/month of morphine sulfate suppository 30 mg?	Y N
[No further questions.]	
15. Does the patient require use of MORE than 270 tablets/month of morphine sulfate 15 mg tablets OR MORE than 180 tablets/month of morphine sulfate 30 mg tablets?	Y N
[No further questions.]	
16. Does the patient require use of MORE than any of the following: A) 270 capsules or tablets/month of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 180 tablets/month of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg D) 120 tablets/month of oxycodone 30 mg or RoxyBond 30 mg?	Y N
[No further questions.]	
17. Does the patient require use of MORE than 180 mL/month of oxycodone oral concentrate 100 mg/5 mL (20 mg/mL) OR MORE than 2700 mL/month of oxycodone oral solution 5 mg/5 mL?	Y N
[No further questions.]	
18. Does the patient require use of MORE than 360 tablets/month of oxymorphone 5 mg OR MORE than 180 tablets/month of oxymorphone 10 mg?	Y N
[No further questions.]	
19. Does the patient require use of MORE than 300 pentazocine/naloxone tablets/month?	Y N
[No further questions.]	
20. Does the patient require use of MORE than any of the following: A) 240 tablets/month of Nucynta (tapentadol) 50 mg, B) 180 tablets/month of Nucynta (tapentadol) 75 mg, C) 120 tablets/month of Nucynta (tapentadol) 100 mg?	Y N
[No further questions.]	
21. Does the patient require use of MORE than 240 tablets/month of tramadol?	Y N
[No further questions.]	
22. Does the patient require use of MORE than 840 mL/month of codeine sulfate oral solution OR MORE than 84 tablets/month of codeine sulfate tablets?	Y N
[No further questions.]	

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23. Does the patient require use of MORE than any of the following: A) 1500 mL/month of hydromorphone liquid, B) 180 hydromorphone suppositories/month, C) 270 tablets/month of hydromorphone 2 mg, D) 225 tablets/month of hydromorphone 4 mg, E) 90 tablets/month of hydromorphone 8 mg?	Y N
[No further questions.]	
24. Does the patient require use of MORE than 180 levorphanol tablets/month?	Y N
[No further questions.]	
25. Does the patient require use of MORE than 120 mL/month of meperidine oral solution OR MORE than 24 tablets/month of meperidine tablets?	Y N
[No further questions.]	
26. Does the patient require use of MORE than 270 mL/month of morphine sulfate oral concentrate solution OR MORE than 1350 mL/month of morphine sulfate oral solution?	Y N
[No further questions.]	
27. Does the patient require use of MORE than 270 suppositories/month of morphine sulfate suppository 5 mg, 10 mg, 20 mg OR MORE than 180 suppositories/month of morphine sulfate suppository 30 mg?	Y N
[No further questions.]	
28. Does the patient require use of MORE than 270 tablets/month of morphine sulfate 15 mg tablets OR MORE than 180 tablets/month of morphine sulfate 30 mg tablets?	Y N
[No further questions.]	
29. Does the patient require use of MORE than any of the following: A) 270 capsules or tablets/month of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 180 tablets/month of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg D) 120 tablets/month of oxycodone 30 mg or RoxyBond 30 mg?	Y N
[No further questions.]	
30. Does the patient require use of MORE than 180 mL/month of oxycodone oral concentrate 100 mg/5 mL (20 mg/mL) OR MORE than 2700 mL/month of oxycodone oral solution 5 mg/5 mL?	Y N
[No further questions.]	
31. Does the patient require use of MORE than 360 tablets/month of oxymorphone 5 mg OR MORE than 180 tablets/month of oxycodone 10 mg?	Y N
[No further questions.]	

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32. Does the patient require use of MORE than 300 pentazocine/naloxone tablets/month?	Y N
[No further questions.]	
33. Does the patient require use of MORE than any of the following: A) 240 tablets/month of Nucynta (tapentadol) 50 mg, B) 180 tablets/month of Nucynta (tapentadol) 75 mg, C) 120 tablets/month of Nucynta (tapentadol) 100 mg?	Y N
[No further questions.]	
34. Does the patient require use of MORE than 240 tablets/month of tramadol?	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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