PreferredOne®

Please follow-up with PreferredOne Customer Service
(800.997.1750 Option #3) for Approval/Denial status of this request.

Long-acting Opioid Prior Authorization

Attn: Pharmacy Dept. Fax (763.847.4014) **All fields required.**
Incomplete and/or Incorrect forms will be returned.

MEMBER INFORMATION

MEMBER NAME:

MEMBER ID: | DATE OF BIRTH: | GENDER: ☐ M ☐ F ☐ O

ADDRESS: | CITY: | STATE: | ZIP:

PROVIDER INFORMATION

PROVIDER NAME: *(FIRST & LAST)* | NPI NUMBER: | SPECIALTY:

CLINIC NAME: | CONTACT: *(NAME & PHONE)* | SECURE FAX/EMAIL:

ADDRESS: | CITY: | STATE: | ZIP:

PHARMACY NAME: | PHARMACY PHONE: | PHARMACY FAX:

MEDICATION REQUESTED

DRUG NAME AND STRENGTH: | DIAGNOSIS (ICD-10):

DIRECTIONS: | ANTICIPATED DURATION OF THERAPY: ________ DAYS OR ________ WEEKS OR ________ MONTHS

IS THE PATIENT CURRENTLY BEING TREATED WITH REQUESTED DRUG? ☐ YES ☐ NO
IF YES, PLEASE INDICATE DATE TREATMENT BEGAN:

IS THIS REQUEST FOR TREATMENT OF CANCER RELATED PAIN OR AS PART OF END OF LIFE CARE? ☐ YES ☐ NO
IF YES, STOP. NO FURTHER INFORMATION IS REQUIRED.

FOR LONG-ACTING OPIOID AUTHORIZATIONS

WHAT IS THE PATIENT'S TOTAL DAILY MORPHINE EQUIVALENT DOSE (MED)? ________ MG/DAY

ARE TREATMENT GOALS DEFINED FOR THE PATIENT? ☐ YES ☐ NO

DOES THE TREATMENT PLAN INCLUDE THE USE OF NONOPIOID ANALGESIC AND/OR NONPHARMACOLOGIC INTERVENTION? ☐ YES ☐ NO

DOES THE PATIENT DEMONSTRATE MEANINGFUL IMPROVEMENT IN PAIN AND FUNCTION USING A VALIDATED INSTRUMENT (E.G. BRIEF PAIN INVENTORY)?
☐ YES ☐ NO

HAS THE PATIENT BEEN SCREENED FOR SUBSTANCE ABUSE/OPIOID DEPENDENCE? ☐ YES ☐ NO

IS THE MEDICATION CURRENTLY BEING TAPERED WITH PLANS FOR DISCONTINUATION? ☐ YES ☐ NO
IF NO, PLEASE SELECT ALL REASONS THAT APPLY:
☐ DEMONSTRATED IMPROVEMENT IN TREATMENT GOALS ☐ PAIN SCORES REMAIN ELEVATED ☐ BENEFITS OUTWEIGH RISKS
☐ OTHER:

HAS THE PATIENT BEEN SCREENED FOR COMORBID MENTAL HEALTH CONDITIONS? ☐ YES ☐ NO

HAS THE PRESCRIBER VIEWED THE PRESCRIPTION DRUG MONITORING PROGRAM (PDMP) (IF ONE IS AVAILABLE IN THE STATE) TO SEE APPROPRIATE CONTROLLED SUBSTANCE USE BY THE PATIENT? ☐ YES ☐ NO

HAS THE PATIENT BEEN ASSESSED FOR RISK OF RESPIRATORY DEPRESSION INCLUDING USE OF CONCURRENT MEDICATIONS (E.G. MEDICAL COMORBIDITIES, BENZODIAZEPINES, DRUG-DRUG INTERACTIONS ETC.)? ☐ YES ☐ NO

MEDICATIONS TRIED AND FAILED FOR INITIAL LONG-ACTING OPIOID AUTHORIZATIONS

DRUG NAME AND STRENGTH: | DIRECTIONS: | DATES:

ADVERSE REACTION TO OR FAILURE OF ALTERNATIVE: ☐ YES ☐ NO IF YES, LIST REACTION OR FAILURE:

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ADVERSE REACTION TO OR FAILURE OF ALTERNATIVE: ☐ YES ☐ NO IF YES, LIST REACTION OR FAILURE:

DRUG NAME AND STRENGTH: | DIRECTIONS: | DATES:

ADVERSE REACTION TO OR FAILURE OF ALTERNATIVE: ☐ YES ☐ NO IF YES, LIST REACTION OR FAILURE:

Please note that this, and other PreferredOne prescription prior authorization requests, can be completed online at **PreferredOne.com/providers**.
For assistance locating these forms, please reach out to PreferredOne Customer Service at 800.997.1750 Option #3.