OPIOID POLICY
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/pharmacy/rx-prior-auth

PATIENT AND INSURANCE INFORMATION **Today's Date:**

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis-ICD code plus description:

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Does the patient have a diagnosis of cancer, palliative care or hospice care in the last 365 days? ☐ Yes ☐ No
3. Does the patient have a total of less than or equal to 7 days supply of opioids in the past 60 days? ☐ Yes ☐ No
   If yes, is the days supply of the requested medication greater than 10 days? ☐ Yes ☐ No
4. Is the request for a long-acting opioid agent? ☐ Yes ☐ No
5. Is the incoming requested drug dosage greater than 90 morphine milligram equivalents (MME)? ☐ Yes ☐ No
6. What is the patient's total opiate intake per day? _____ Morphine milligram equivalents(MME)
7. Is the incoming request for greater than a 34-day supply? ☐ Yes ☐ No
8. Please list the medications the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if brand name, generic, extended-release products, or over-the-counter products)**:**

   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
9. Please list all reasons for selecting the **requested medication and dose** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions). _____
10. Please list all other medications the patient is **currently taking** for treatment of this diagnosis. _____

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Please fax or mail this form to:
Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.243.6930 **Phone: 855.457.0407**

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