

7. Has the prescriber reviewed the patient's history of controlled substance prescriptions in the state Prescription Drug Monitoring Program (PDMP)? Y N
8. Has the patient tried at least one non-opioid medication that did not adequately control pain? If yes, then document the name of the medication(s) and trial date(s): Medication(s): Trial Date(s):
_____ Y N
9. Is a trial of a non-opioid medication inappropriate for this patient? If yes, then list reason why patient cannot try a non-opioid medication.
_____ Y N
10. Have lower doses of an opioid medication been used that did not adequately control pain? If yes, then list the medication regimen and date of therapy: Medication Regimen: Date of Therapy:
_____ Y N
11. Is this request for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days? Y N
12. Does the patient have severe continuous pain and has the patient received an immediate-release opioid for at least one week? Y N
13. Has the dosing information for the requested drug been documented below? Medication Name and Strength: Dosage form (e.g., tablets, oral solution, etc.): Directions for Use: Quantity Requested on prescription: Number of days prescription is expected to last:
_____ Y N
14. Which drug is being requested? Please check the drug being requested.
- Arymo ER (morphine extended-release tablets) (if checked, go to 26)
 - Avinza (morphine extended-release capsules) (if checked, go to 18)
 - Belbuca (buprenorphine buccal film) (if checked, go to 19)
 - Butrans (buprenorphine transdermal system) (if checked, go to 20)
 - Conzip (tramadol hydrochloride extended-release) (if checked, go to 21)
 - Dolophine 5 mg, 10 mg (methadone hydrochloride tablets) (if checked, go to 16)
 - Duragesic (fentanyl transdermal system) (if checked, go to question 22)
 - Embeda (morphine sulfate/naltrexone HCl extended-release) (if checked, go to question 23)
 - Exalgo (hydromorphone HCl extended-release tabs) (if checked, go to question 24)
 - Hysingla ER (hydrocodone bitartrate extended-release tablets) (if checked, go to 15)
 - Kadian (morphine extended-release capsules) (if checked, go to question 25)
 - Methadone 10 mg/mL Intensol soln (if checked, go to 16)
 - Methadone 5 mg/5 mL, 10 mg/5 mL oral soln, 200 mg/20 mL injection (if checked, go to 16)
 - Methadone 5 mg, 10 mg (methadone hydrochloride tablets) (if checked, go to 16)
 - MorphaBond ER (morphine extended-release tablets) (if checked, go to 26)
 - MS Contin (morphine extended-release tablets) (if checked, go to 26)
 - Nucynta ER (tapentadol extended-release tablets) (if checked, go to 27)
 - Opana ER (oxymorphone hydrochloride extended-release tablets) (if checked, go to 28)
 - OxyContin (oxycodone hydrochloride extended-release tablets) (if checked, go to 29)
 - Targiniq ER (oxycodone HCl/naloxone HCl extended-release tablets) (if checked, go to 30)
 - Tramadol hydrochloride extended-release (if checked, go to 21)
 - Ultram ER (tramadol hydrochloride extended-release tablets) (if checked, go to 21)
 - Vantrela ER (hydrocodone bitartrate extended-release tablets) (if checked, go to 15)

Xtampza ER (oxycodone extended-release capsules) (if checked, go to 31)

Zohydro ER (hydrocodone bitartrate extended-release capsules) (if checked, go to 15)

Troxyca ER (oxycodone/naltrexone extended-release capsules) (if checked, go to 32)

[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.]

15. Does the patient require use of MORE than the plan allowance of any of the following: A) 3 units per day of Zohydro ER 10 mg, 15 mg, 20 mg, 30 mg, 40 mg OR Vantrela ER 15 mg, 30 mg, 45 mg, B) 2 units per day 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, C) 1 unit per day of Hysingla ER 120 mg? Y N
16. Is the requested methadone product being prescribed for detoxification treatment or as part of a maintenance treatment plan for opioid/substance abuse or addiction? Y N
17. Does the patient require use of MORE than the plan allowance of any of the following: A) 4 tablets per day of Dolophine 5 mg or Methadone 5 mg, B) 3 tablets per day of Dolophine 10 mg or Methadone 10 mg, C) 20 mL per day of Methadone 5 mg/5 mL oral solution, D) 15 mL per day of Methadone 10 mg/5 mL oral solution, E) 1.333 mL per day (i.e., 2 multidose vials per month) of Methadone 200 mg/20 mL injection, F) 3 mL per day of Methadone 10 mg/mL Intensol solution? Y N
18. Does the patient require use of MORE than the plan allowance of 2 capsules per day of Avinza 30 mg, 45 mg, 60 mg, 75 mg, 90 mg OR MORE than the plan allowance of 1 capsule per day of Avinza 120 mg? Y N
19. Does the patient require use of MORE than the plan allowance of 3 films per day of Belbuca 75 mcg, 150 mcg, 300 mcg, 450 mcg OR MORE than the plan allowance of 2 films per day of Belbuca 600 mcg, 750 mcg, 900 mcg? Y N
20. Does the patient require use of MORE than the plan allowance of 0.286 patch per day (i.e., 2 patches per week) of Butrans 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr OR MORE than the plan allowance of 0.143 patch per day (i.e., 1 patch per week) of Butrans 15 mcg/hr, 20 mcg/hr? Y N
21. Does the patient require use of MORE than the plan allowance of 2 units per day of Conzip 100 mg, tramadol ER 100 mg, 150 mg, or Ultram ER 100 mg, OR MORE than the plan allowance of 1 unit per day of Conzip 200 mg, 300 mg, or tramadol ER 200 mg, 300 mg, or Ultram ER 200 mg, 300 mg? Y N
22. Does the patient require use of MORE than the plan allowance of 0.666 patch per day (i.e., 2 patches per 3 days) of Duragesic 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hr OR MORE than the plan allowance of 0.333 patch per day (i.e., 1 patch per 3 days) of Duragesic 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr, 100 mcg/hr? Y N
23. Does the patient require use of MORE than the plan allowance of 3 capsules per day of Embeda 20 mg/0.8 mg, 30 mg/1.2 mg OR MORE than the plan allowance of 2 capsules per day of Embeda 50 mg/2 mg, 60 mg/2.4 mg, 80 mg/3.2 mg, 100 mg/4 mg? Y N
24. Does the patient require use of MORE than the plan allowance of 2 tablets per day of Exalgo 8 mg, 12 mg, 16 mg OR MORE than the plan allowance of 1 tablet per day of Exalgo 32 mg? Y N
25. Does the patient require use of MORE than the plan allowance of any of the following: A) 3 capsules per day of Kadian 10 mg, 20 mg, 30 mg, 40 mg, B) 2 capsules per day of Kadian 50 mg, 60 mg, 70 mg, 80 mg, 100 mg, C) 1 capsule per day of Kadian 130 mg, 150 mg, 200 mg? Y N
26. Does the patient require use of MORE than the plan allowance of any of the following: A) 4 tablets per day of Arymo ER 15 mg, 30 mg or MorphaBond ER 15 mg, 30 mg or MS Contin 15 mg, 30 mg, B) 3 tablets per day of Arymo ER 60 mg or MorphaBond ER 60 mg or MS Contin 60 mg, C) 2 tablets per day of MorphaBond ER 100 mg or MS Contin 100 mg, 200 mg? Y N
27. Does the patient require use of MORE than the plan allowance of 3 tablets per day of Nucynta ER 50 mg, 100 mg, 150 mg OR MORE than the plan allowance of 2 tablets per day of Nucynta ER 200 mg, 250 mg? Y N
28. Does the patient require use of MORE than the plan allowance of 3 tablets per day of Opana ER 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, OR MORE than the plan allowance of 2 tablets per day of Opana ER 30 mg, 40 mg? Y N
29. Does the patient require use of MORE than the plan allowance of 3 tablets per day of OxyContin 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, OR MORE than the plan allowance of 2 tablets per day of OxyContin 60 mg, 80 mg? Y N

30. Does the patient require use of MORE than the plan allowance of 3 tablets per day of Targiniq ER 10 mg/5 mg, 20 mg/10 mg OR MORE than the plan allowance of 2 tablets per day of Targiniq ER 40 mg/20 mg? Y N
31. Does the patient require use of MORE than the plan allowance of 3 capsules per day of Xtampza ER? Y N
32. Does the patient require use of MORE than the plan allowance of 3 capsules per day of Troxyca ER 10 mg/1.2 mg, 20 mg/2.4 mg, 30 mg/3.6 mg, 40 mg/4.8 mg OR MORE than the plan allowance of 2 capsules per day of Troxyca ER 60 mg/7.2 mg, 80 mg/9.6 mg? Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.