CAREFIRST F1
Opioids IR - 3-Day Acute Pain Duration Limit for 19 and Under with MME Limit and Post Limit

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 866-217-5644. Please contact CVS/Caremark at 844-449-8734 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Opioids IR - 3-Day Acute Pain Duration Limit for 19 and Under with MME Limit and Post Limit.

Patient Information

Patient Name:

Patient Phone: - -

Patient ID:

Patient Group No:

Patient DOB: / /

Prescribing Physician

Physician Name:

Physician Phone: - -

Physician Fax: - -

Physician Address:

City, State, Zip:

Drug Name (specify drug) ____

Quantity: ____________ **Frequency:** __________________ **Strength:** __________________

Route of Administration: _______________________ **Expected Length of Therapy:** _____________________

Diagnosis: ___________________________________ **ICD Code:** ___________________________________

Comments: ____
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Please check the appropriate answer for each applicable question.

1. Is the requested drug being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through hospice or palliative care? Chart notes supporting diagnosis must be submitted if Clinical Condition and ICD Code are not documented above. If yes, then list clinical condition and the ICD diagnosis code that supports the diagnosis: Clinical Condition: ICD Code: ____ **Y** ☐ **N** ☐

2. Can the patient safely take the requested dose based on their history of opioid use? **Y** ☐ **N** ☐

   [Note: The lowest effective dosage should be prescribed for opioid naive patients.]

3. Has the prescriber completed an assessment of increased risk for respiratory depression and overdose, including the use of concomitant medications (e.g., benzodiazepines)? **Y** ☐ **N** ☐
   [Note: Prescribers should consider offering naloxone when factors that increase risk for opioid overdose are present (e.g., history of overdose, history of substance use disorder, higher opioid dosages (50 MME/day or greater), or concurrent benzodiazepine use).]

4. Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder? **Y** ☐ **N** ☐

5. Has the prescriber reviewed the patient's history of controlled substance prescriptions in the state Prescription Drug Monitoring Program (PDMP)? **Y** ☐ **N** ☐

6. 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** ☐

7. 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 ☐

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8. 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 ☐

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9. 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.]

10. Will the patient's pain be reassessed in the first month after the initial prescription AND every 3 months thereafter to evaluate if there is a need to taper and to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety? Y ☐ N ☐

11. 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 ☐

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12. Does the patient require extended treatment beyond 3 days for moderate to severe ACUTE pain where use of an opioid analgesic is appropriate? Y ☐ N ☐

13. Which drug is being requested (applies to brand or generic)?
   - codeine tablets (if checked, go to 15) ☐
   - hydromorphone oral solution, suppositories, or tablets (if checked, go to 16) ☐
   - levorphanol tablets (if checked, go to 17) ☐
   - meperidine oral solution or tablets (if checked, go to 18) ☐
   - morphine sulfate oral concentrate or oral solution (if checked, go to 19) ☐
   - morphine sulfate suppositories (if checked, go to question 20) ☐
   - morphine sulfate tablets (if checked, go to question 21) ☐
   - oxycodone, Oxaydo, or RoxyBond capsules or tablets (if checked, go to question 22) ☐
   - oxycodone oral concentrate or oral solution (if checked, go to 23) ☐
   - oxymorphone tablets (if checked, go to question 24) ☐
   - pentazocine/naloxone tablets (if checked, go to 25) ☐
   - tapentadol oral solution or tablets (Nucynta) (if checked, go to 26) ☐
   - tramadol tablets (if checked, go to 27) ☐

   [Note: Please check the drug being requested (applies to brand or generic).]

14. Which drug is being requested (applies to brand or generic)?
   - codeine tablets (if checked, go to 28) ☐
   - hydromorphone oral solution, suppositories, or tablets (if checked, go to 29) ☐
   - levorphanol tablets (if checked, go to 30) ☐
   - meperidine oral solution or tablets (if checked, go to 31) ☐
   - morphine sulfate oral concentrate or oral solution (if checked, go to 32) ☐
   - morphine sulfate suppositories (if checked, go to question 33) ☐
   - morphine sulfate tablets (if checked, go to question 34) ☐
   - oxycodone, Oxaydo, or RoxyBond capsules or tablets (if checked, go to question 35) ☐
   - oxycodone oral concentrate or oral solution (if checked, go to 36) ☐
   - oxymorphone tablets (if checked, go to question 37) ☐
   - pentazocine/naloxone tablets (if checked, go to 38) ☐

tapentadol oral solution or tablets (Nucynta) (if checked, go to 39) ☐

tramadol tablets (if checked, go to 40) ☐

[Note: Please check the drug being requested (applies to brand or generic).]

15. Does the patient require use of MORE than the plan allowance of 6 codeine sulfate tablets per day? **Y** ☐ **N** ☐

16. Does the patient require use of MORE than the plan allowance of any of the following: A) 50 mL per day of hydromorphone oral solution, B) 6 hydromorphone suppositories per day, C) 9 tablets per day of hydromorphone 2 mg, D) 7.5 tablets per day of hydromorphone 4 mg, E) 3 tablets per day of hydromorphone 8 mg? **Y** ☐ **N** ☐

17. Does the patient require use of MORE than the plan allowance of 6 levorphanol tablets per day? **Y** ☐ **N** ☐

18. Does the patient require use of MORE than the plan allowance of 30 mL per day of meperidine oral solution OR MORE than the plan allowance of 6 meperidine tablets per day? **Y** ☐ **N** ☐

19. Does the patient require use of MORE than the plan allowance of 9 mL per day of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution OR MORE than the plan allowance of 45 mL per day of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution? **Y** ☐ **N** ☐

20. Does the patient require use of MORE than the plan allowance of 9 suppositories per day of morphine sulfate 5 mg, 10 mg, 20 mg OR MORE than the plan allowance of 6 suppositories per day of morphine sulfate 30 mg? **Y** ☐ **N** ☐

21. Does the patient require use of MORE than the plan allowance of 9 tablets per day of morphine sulfate 15 mg OR MORE than the plan allowance of 6 tablets per day of morphine sulfate 30 mg? **Y** ☐ **N** ☐

22. Does the patient require use of MORE than the plan allowance of any of the following: A) 9 capsules or tablets per day of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 6 tablets per day of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 4 tablets per day of oxycodone 30 mg or RoxyBond 30 mg? **Y** ☐ **N** ☐

23. Does the patient require use of MORE than the plan allowance of 6 mL per day of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate OR MORE than the plan allowance of 90 mL per day of oxycodone 5 mg/5 mL oral solution? **Y** ☐ **N** ☐

24. Does the patient require use of MORE than the plan allowance of 12 tablets per day of oxymorphone 5 mg OR MORE than the plan allowance of 6 tablets per day of oxymorphone 10 mg? **Y** ☐ **N** ☐

25. Does the patient require use of MORE than the plan allowance of 10 pentazocine/naloxone tablets per day? **Y** ☐ **N** ☐

26. Does the patient require use of MORE than the plan allowance of any of the following: A) 8 tablets per day of Nucynta (tapentadol) 50 mg, B) 6 tablets per day of Nucynta (tapentadol) 75 mg, C) 4 tablets per day of Nucynta (tapentadol) 100 mg, D) 23.33 mL per day of Nucynta (tapentadol) oral solution? **Y** ☐ **N** ☐

27. Does the patient require use of MORE than the plan allowance of 8 tablets per day of tramadol 50 mg OR MORE than the plan allowance of 4 tablets per day of tramadol 100 mg? **Y** ☐ **N** ☐

28. Does the patient require use of MORE than the plan allowance of 6 codeine sulfate tablets per day? **Y** ☐ **N** ☐

29. Does the patient require use of MORE than the plan allowance of any of the following: A) 50 mL per day of hydromorphone oral solution, B) 6 hydromorphone suppositories per day, C) 9 tablets per day of hydromorphone 2 mg, D) 7.5 tablets per day of hydromorphone 4 mg, E) 3 tablets per day of hydromorphone 8 mg? **Y** ☐ **N** ☐

30. Does the patient require use of MORE than the plan allowance of 6 levorphanol tablets per day? **Y** ☐ **N** ☐

31. Does the patient require use of MORE than the plan allowance of 30 mL per day of meperidine oral solution OR MORE than the plan allowance of 6 meperidine tablets per day? **Y** ☐ **N** ☐

32. Does the patient require use of MORE than the plan allowance of 9 mL per day of morphine sulfate 20 mg/mL (100 mg/5 mL) oral concentrate solution OR MORE than the plan allowance of 45 mL per day of morphine sulfate 10 mg/5 mL or 20 mg/5 mL oral solution? **Y** ☐ **N** ☐

33. Does the patient require use of MORE than the plan allowance of 9 suppositories per day of morphine sulfate 5 mg, 10 mg, 20 mg OR MORE than the plan allowance of 6 suppositories per day of morphine sulfate 30 mg? **Y** ☐ **N** ☐

34. Does the patient require use of MORE than the plan allowance of 9 tablets per day of morphine sulfate 15 mg OR MORE than the plan allowance of 6 tablets per day of morphine sulfate 30 mg? **Y** ☐ **N** ☐

35. Does the patient require use of MORE than the plan allowance of any of the following: A) 9 capsules or tablets per day of oxycodone 5 mg, 10 mg, Oxaydo 5 mg or 7.5 mg, or RoxyBond 5 mg, B) 6 tablets per day of oxycodone 15 mg, 20 mg, or RoxyBond 15 mg C) 4 tablets per day of oxycodone 30 mg or RoxyBond 30 mg? **Y** ☐ **N** ☐

36. Does the patient require use of MORE than the plan allowance of 6 mL per day of oxycodone 100 mg/5 mL (20 mg/mL) oral concentrate OR MORE than the plan allowance of 90 mL per day of oxycodone 5 mg/5 mL oral solution? **Y** ☐ **N** ☐

37. Does the patient require use of MORE than the plan allowance of 12 tablets per day of oxymorphone 5 mg OR MORE than the plan allowance of 6 tablets per day of oxymorphone 10 mg? **Y** ☐ **N** ☐

38. Does the patient require use of MORE than the plan allowance of 10 pentazocine/naloxone tablets per day? **Y** ☐ **N** ☐

39. Does the patient require use of MORE than the plan allowance of any of the following: A) 8 tablets per day of Nucynta (tapentadol) 50 mg, B) 6 tablets per day of Nucynta (tapentadol) 75 mg, C) 4 tablets per day of Nucynta (tapentadol) 100 mg, D) 23.33 mL per day of Nucynta (tapentadol) oral solution? **Y** ☐ **N** ☐

40. Does the patient require use of MORE than the plan allowance of 8 tablets per day of tramadol 50 mg OR MORE than the plan allowance of 4 tablets per day of tramadol 100 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.

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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.