

**CAREFIRST - MD EXCHANGE 5T  
Opioids IR - APAP-ASA-IBU Combo Products - 3-Day Acute Pain Duration Limit for 19 and Under**

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 - APAP-ASA-IBU Combo Products - 3-Day Acute Pain Duration Limit for 19 and Under.

**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:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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? **Y**  **N**
2. 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.]
3. Does the patient require extended treatment beyond 3 days for ongoing management of ACUTE pain? **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**

Effective July 1, 2015, Maryland law will require providers to submit pharmaceutical preauthorization requests electronically. To use ePA, either contact your electronic health record vendor or visit [www.covermymeds.com/epa/caremark](http://www.covermymeds.com/epa/caremark)