Please note: All information below is required to process this request.
**Fax to 1-844-403-1029**
**Mon-Sat: 7am to 7pm Central**

# Brand Name narcotics Prior Authorization Request Form (Page 1 of 2)

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

| Medication Information (required) | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Medication history:**

Has the patient had a trial and failure (at least a 30 day trial) of a generic narcotic in the past 90 days? ❑ **Yes** ❑ **No**

**Clinical information:**

Does the patient have a diagnosis of cancer in the past 365 days? ❑ **Yes** ❑ **No**

Does the patient have a diagnosis of a terminal illness? ❑ **Yes** ❑ **No**

Does the patient have an illness associated with significant pain (e.g., sickle cell anemia, etc)? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: ______________________________________________

Does the patient have an injury associated with significant pain? ❑ **Yes** ❑ **No**

If **yes**, please list the diagnosis: ______________________________________________

Have efforts been made to taper the patient to the lowest effective dose? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: __________________________________________

______________________________________________________________________

______________________________________________________________________

**Reauthorization:**

**If this is a reauthorization request, answer the following:**

Is the prescriber maintaining the most conservative, effective treatment? ❑ **Yes** ❑ **No**

If **yes**, please provide documentation: __________________________________________

______________________________________________________________________

______________________________________________________________________

**Quantity limit requests:**

**What is the patient's diagnosis for the medication being requested?**

____________________________________________ ICD-10 Code(s): ____________________

What is the quantity requested per MONTH? ________

**What is the reason for exceeding the plan limitations?**

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: ______________________________________________________________

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# Brand Name narcotics Prior Authorization Request Form (Page 2 of 2)

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**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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