



## Morphine Equivalent Dose (MED) Limit Prior Authorization Request Form

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

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<p><b>Clinical information:</b></p> <p>Does the patient have a diagnosis of cancer in the past 365 days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a diagnosis of a terminal illness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have an <u>illness</u> associated with significant pain (e.g., sickle cell anemia, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>yes</b>, please list the diagnosis: _____</p> <p>Does the patient have an <u>injury</u> associated with significant pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>yes</b>, please list the diagnosis: _____</p> <p>Have efforts been made to taper the patient to the lowest effective dose? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>yes</b>, please provide documentation: _____</p> <p>_____</p> <p>_____</p>					
<p><b>Reauthorization:</b></p> <p><b>If this is a reauthorization request, answer the following:</b></p> <p>Is the prescriber maintaining the most conservative, effective treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If <b>yes</b>, please provide documentation: _____</p> <p>_____</p> <p>_____</p>					

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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**  
Office use only: MorphineEquivalentDose\_SouthDakotaMedicaid\_2018Sep