

## **Opioid Naïve Prior Authorization Request Form**

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

Member Information (required)			<b>Provider Information</b> (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:
		<b>Medication Inf</b>	ormation (required	d)	
Medication Name:			Strength:	·	Dosage Form:
Check if requesting brand			Directions for Use:		
Check if request is	for continuation of the	erapy			
Clinical Information (required)					
Clinical information:					
Does the patient have a diagnosis of cancer in the past 365 days? <b>□ Yes □ No</b>					
Does the patient have a diagnosis of a terminal illness? D Yes D No					
Does the patient have an illness associated with significant pain (e.g., sickle cell anemia, major surgery, etc)? <b>U Yes D</b> No					
If <b>yes</b> , please list th	ne diagnosis:				
Does the patient have an injury associated with significant pain? <b>D</b> Yes <b>D</b> No					
If <b>yes</b> , please list th	ne diagnosis:				
Have efforts been made to taper the patient to the lowest effective dose? <b>D</b> Yes <b>D</b> No					
If <b>yes</b> , please provide documentation:					
•			<b>, , , , , ,</b>		

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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