NC Medicaid
Pharmacy Prior Approval Request for
Short-Acting Opioid Analgesic

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days

Clinical Information

1. Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ☐ Yes ☐ No If yes, the patient is exempt from the prior authorization requirement
2. Does the patient have Sickle Cell Disease? ☐ Yes ☐ No
3. Is this an initial authorization request? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request. ☐ Yes ☐ No
   3a. If No, please attach documentation as to why the beneficiary needs continued opioid treatment and current plan of care.
4. Is the requested daily dose in combination with other concurrent opioids less than or equal to 90mg of morphine or an equivalent dose? ☐ Yes ☐ No Answer questions 4a and 4b when the response to question 4 is 'No'.
   4a. Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits.
   Please list: _____
   4b. Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose.
   Please list: _____
5. Has the prescriber reviewed and is adhering to the N.C. Medical Board statement on the use of controlled substances for the treatment of pain? ☐ Yes ☐ No
6. Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate? ☐ Yes ☐ No
7. Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System? ☐ Yes ☐ No
8. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? ☐ Yes ☐ No

Non-Preferred Products:

9. Does the patient have a documented history within the past year of two preferred short-acting Opioid Analgesics at a dose equal to or equivalent to the non-preferred long-acting Opioid Analgesic being prescribed? ☐ Yes ☐ No
   Please list: _____
10. Does the patient have a contraindication or allergy to ingredients in the preferred products? ☐ Yes ☐ No
    Please list: _____

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505

DHB Pharmacy __