



**NC Medicaid and NC Health Choice
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 Other: _____

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 long-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 product? **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.