NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Long-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

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 beneficiary have a diagnosis of moderate to severe pain with need for around-the-clock analgesia for an extended period? ☐ Yes ☐ No
3. 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 3a and 3b when the response to question 3 is 'No'.
   3a. Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits. Please list: _____
   _____
   3b. Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose. Please list:
   _____
4. Is this an initial authorization request? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request. ☐ Yes ☐ No
   4a. If Yes, has the beneficiary tried a short-acting Opioid Analgesic in the past 45 days? ☐ Yes ☐ No
   4b. If no, explain: _____
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.

Fax this form to CSRA at (855) 710-1969
DHB Pharmacy 66

Pharmacy PA Call Center: (866) 246-8505
08.02.2023