REALRx

PRIOR AUTHORIZATION REQUEST FORM
ACUTE OPIOID USE

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: _____

Dosing/Frequency:_____

Acute opioid coverage is limited to 7 days of therapy within any 60 days. Quantity limits and dose limits apply for acute opioid therapy. Long-acting opioids are not covered for acute use.

Opioid use beyond 30 days will be subject to additional coverage criteria. Please refer to Chronic Opioids Policy.

Please answer the following:

Questions	Yes	No	Comments/Notes
1. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
2. Does the member have a diagnosis of active cancer? **If documentation supports active cancer therapy, no additional questions are required.**	☐	☐	**Please provide documentation**
3. Does the member have one of the following: post-operative pain requiring opioid therapy expected to last longer than 7 days, treatment of nocturnal dyspnea, or treatment of acute sickle cell crisis?	☐	☐	**Please provide documentation, including names, dates, and durations of treatments**
4. Does the member require no more than 7-day supply, except dental use (limit to a 3 day supply)?	☐	☐	
5. Does the member require continuous opioid use beyond 30 days? If yes, see Chronic Opioid Policy.	☐	☐	

6. Is the member new to the plan and currently taking chronic short-acting opioid therapy? If yes, see Chronic Opioid Policy.	☐	☐	
7. Does the member require long-acting opioid for acute pain treatment? If yes, see Chronic Opioid Policy.	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy: PHARM 052
Origination Date: 08/21/2017
Reviewed/Revised Date: 08/24/2022
Next Review Date: 08/24/2023
Current Effective Date: 09/01/2022