

Member Name:

Insurance ID#:

Date of Birth:

Member Information (required)

Prior Authorization Form Acute Opioid Use Up to 15-Day Supply



Revision Date: 12/3/2020

Prescriber Information (required)

DEA#:

Access this PA form at: https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Acute%20Opioid%20PA%20Form.pdf

Provider Name:

If the following information is not complete, correct, or legible, the PA process can be delayed. Use one form per member please.

NPI#:

Specialty:

Street Addres	s:		Office Phone:	Office Phone: Office Fax:						
City:	State:	Zip:	Office Street Address:							
Phone:			City:	State:		Zip:				
			Is the prescriber a TennCare provider with a Medicaid ID? Yes No Is the prescriber a single-patient contract holder for this patient? Yes No							
period not to exce the first-fill. Inform	eed 60 MME per day. The firm mation and separate PA form	st-fill prescription cannot on statement of the statement	ion coverage for non-chronic exceed 5-days. Prior Authoriz e.g. burn or corrosion, sickle website at: https://optumrx	ation is required for cell disorder, use in	r all subsequent LTC facilities, ar	acute prescriptions after				
Go to the follow	ving link to see the most	•	pioid Users are limited to gram Equivalent Conversion	• •	optumrx.com/	oe tenncare/prescriber				
Drug Name: Preferred agents: codeine/APAP, Endocet, hydrocodone/APAP, hydrocodone/IBU, hydromorphone, morphine IR, oxycodone, oxycodone/APAP, tramadol *Non-preferred agent (specify) here:			conversion (see li	Please calculate all short-acting narcotic agents and dosages with MME conversion (see link above) that the patient may be receiving below to obtain the total daily MME amount. Daily MME Formula: (MME/Unit x # Units for Prescription)/Day's Supply of Prescription						
Strength: Directions:			PLEASE LIST all Short Drug Name; strength	1		Daily MME				
Quantity Requested:			Drug Name; strength Drug Name; strength							
			Drug Name; strength							
			Drug Name; strength Daily MME Total Daily MME patient currently receiving for all opioid agents:							

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*With the exception of the "Branded Drugs Classified as Generics" list, TennCare is a mandatory generic program in accordance with state law (TCA 53-10-205).

Approval of NP agents requires trial and failure, contraindication, or intolerance of 2 preferred agents, unless otherwise indicated on the PDL. https://www.optumrx.com/content/dam/openenrollment/pdfs/Tenncare/presciber/prior-authorization-forms/Acute%20Opioid%20PA%20Form.pdf



Prior Authorization FormAcute Opioid Use Up to 15-Day Supply



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	Clinical Criteria Documentation	on ****Do not include documentation	that is	not reques	ted on i	this form**	**	
1.	Does the patient have moderate-severe initial first-fill opioid prescription?	acute pain requiring treatment beyond an	Yes	Yes (indicate diagnosis below) No				
	Diagnosis (specify and list ICD-10):							_
2.	Have non-pharmacologic therapies been	☐ Yes ☐ No						
3.	Has the patient tried non-opioid analges	Yes (if "yes" document below with responses)						
	Non-Opioid Analgesic	Dates		Response				
								_
4.	Does the patient's pain significantly impa (e.g., ADL's, sleep, work)?	airtheir physical functioning	Ye	es \Box	No			
5.	Is the patient currently being treated for	opioid addiction?	Ye	es <u> </u>	No			
6.	•	nas been associated with increased risk of operior ovider assessed the member using a Screenity)?		f Intervent	ion, an		o Treatment	t
7.	For patients 11-18 years of age, has the Treatment (SBIRT) Questionnaire (e.g., <u>CF</u>	provider assessed the member using an adol <u>RAFFT</u> Survey)?	escent Ye		Brief Ir No	ntervention,	and Referral	to
8.	Will this patient be using benzodiazepine	es and opioids concomitantly?	☐ Ye	es 🗌	No			
9.	IF YES, is the patient under the care of or	r been referred to a mental health provider?	☐ Ye	es 🗌	No			
10.	For requests for non-preferred agents, duse a preferred agent? If yes, provide de	oes the patient have a reason they cannot tails below:	☐ Ye	es 🗆	No			
								-
		of 14 and 44, please complete questions 11-			_	to signatu	re section.	
11		nancy has been associated with neonatal abs g the risks of becoming pregnant while recei syndrome?				Yes	□No	
12	. Is this patient pregnant?					☐ Yes	☐ No	
13	. Is this patient currently utilizing a form of	f contraception (e.g. barrier, oral contracepti	ve, rhy	thm metho	d)?	☐ Yes	☐ No	
14. Does this patient have an intrauterine device (IUD) or implant?						☐ Yes	☐ No	
15	. Does this patient have a history of hyster	ectomy, tubal ligation, or endometrial ablati	on?			☐ Yes	□No	
	requests for Opioid-Acetaminophen combin	nation products and total acetaminophen dose	e is betv	veen 3,000	mg to 4	1,000 mg pe	r day.	
16		combination products, go to next section.					res No	
17							res No	
18		n?					res No	
19	. Does the patient have Hepatic Insufficier	ncy?					res No	
Ву		that the benefits of opioid treatment for ided on this form is true and accurate to t	•		_		d verify tha	at the
Prescriber Signature (Required)						Date		
	(By signature, the Physician confirms th	ne above information is accurate and verifitient records.)	able by	y				

Fax this form to: 1-866-434-5523 Phone: 1-866-434-5524

OptumRx will provide a response within 24 hours upon receipt.

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