Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

1358-E Opioids IR - Combo Products Acute Pain Duration Limit

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-866-217-5644**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of 1358-E Opioids IR - Combo Products Acute Pain Duration Limit.

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is one of the following drugs (brand or generic) being requested: A) hydrocodone/ibuprofen tablets, B) oxycodone/ibuprofen tablets, C) tramadol/acetaminophen tablets?	Y N
[If yes, then skip to question 5.]	
2. Is the requested drug being prescribed for pain associated with cancer, a terminal condition, or pain being managed through hospice or palliative care?	Y N
[If yes, then no further questions.]	

3.	Is the requested drug being prescribed for moderate to severe CHRONIC pain where use of an opioid analgesic is appropriate?	Y N
	[Note: Chronic pain is generally defined as pain that typically lasts greater than 3 months.]	
	[If yes, then no further questions.]	
4.	Does the patient require extended treatment beyond 7 days for ongoing management of ACUTE pain?	Y N
	[No further questions.]	
5.	Does the patient require use of MORE than any of the following: A) 50 tablets/month of hydrocodone/ibuprofen tablets B) 28 tablets/month of oxycodone/ibuprofen tablets, C) 40 tablets/month of tramadol/acetaminophen tablets?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date