

Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

1361-M Opioids ER MME Limit and Post 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 1361-M Opioids ER MME Limit and Post 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 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.]

2. Is the requested drug being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid?

Y  N

3. Can the patient safely take the requested dose based on their history of opioid use?

Y  N

4. Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N
5. Will the patient's pain be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety?	<input type="checkbox"/> Y <input type="checkbox"/> N
6. Which drug is being requested? Please check drug being requested.	
[Note: These drugs should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.]	
Arymo ER (morphine extended-release tablets) (if checked, go to 18)	<input type="checkbox"/>
Avinza (morphine extended-release capsules) (if checked, go to 10)	<input type="checkbox"/>
Belbuca (buprenorphine buccal film) (if checked, go to 11)	<input type="checkbox"/>
Butrans (buprenorphine transdermal system) (if checked, go to 12)	<input type="checkbox"/>
Conzip (tramadol hydrochloride extended-release) (if checked, go to 13)	<input type="checkbox"/>
Dolophine 5 mg, 10 mg (methadone hydrochloride tablets) (if checked, go to 8)	<input type="checkbox"/>
Duragesic (fentanyl transdermal system) (if checked, go to question 14)	<input type="checkbox"/>
Embeda (morphine sulfate/naltrexone HCl extended-release) (if checked, go to question 15)	<input type="checkbox"/>
Exalgo (hydromorphone hydrochloride extended-release) (if checked, go to question 16)	<input type="checkbox"/>
Hysingla ER (hydrocodone bitartrate extended-release tablets) (if checked, go to 7)	<input type="checkbox"/>
Kadian (morphine extended-release capsules) (if checked, go to question 17)	<input type="checkbox"/>
Methadone 10 mg/mL Intensol soln (if checked, go to 8)	<input type="checkbox"/>
Methadone 5 mg/5 mL, 10 mg/5 mL oral soln, 200 mg/20 mL injection (if checked, go to 8)	<input type="checkbox"/>
Methadose 5 mg, 10 mg (methadone hydrochloride tablets) (if checked, go to 8)	<input type="checkbox"/>
Morphabond (morphine extended-release tablets) (if checked, go to 18)	<input type="checkbox"/>
MS Contin (morphine extended-release tablets) (if checked, go to 18)	<input type="checkbox"/>
Nucynta ER (tapentadol extended-release) (if checked, go to 19)	<input type="checkbox"/>

Opana ER (oxymorphone hydrochloride extended-release tablets) (if checked, go to 20)	<input type="checkbox"/>
OxyContin (oxycodone hydrochloride extended-release tablet) (if checked, go to 21)	<input type="checkbox"/>
Targiniq ER (oxycodone HCl/naloxone HCl extended-release tablets) (if checked, go to 22)	<input type="checkbox"/>
tramadol extended-release (if checked, go to 13)	<input type="checkbox"/>
Ultram ER (tramadol extended-release) (if checked, go to 13)	<input type="checkbox"/>
Vantrela ER (hydrocodone bitartrate extended-release tablets) (if checked, go to 7)	<input type="checkbox"/>
Xtampza ER (oxycodone extended-release capsules) (if checked, go to 23)	<input type="checkbox"/>
Zohydro ER (hydrocodone bitartrate extended-release capsules) (if checked, go to 7)	<input type="checkbox"/>
Troxyca ER (oxycodone/naltrexone extended-release capsules) (if checked, go to 24)	<input type="checkbox"/>
7. Does the patient require use of MORE than any of the following: A) 60 units/month of Hysingla ER 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg OR Zohydro ER 50 mg OR Vantrela ER 60 mg, 90 mg, B) 30 units/month of Hysingla ER 120 mg, C) 90 units/month of Zohydro ER 10 mg, 15 mg, 20 mg, 30 mg, 40 mg OR Vantrela ER 15 mg, 30 mg, 45 mg?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
8. Is the methadone product being prescribed for detoxification treatment or as part of a maintenance treatment plan for opioid/substance abuse or addiction?	<input type="checkbox"/> Y <input type="checkbox"/> N
9. Does the patient require use of MORE than any of the following: A) 120 tablets/month of Dolophine 5 mg or Methadose 5 mg, B) 90 tablets/month of Dolophine 10 mg or Methadose 10 mg, C) 600 mL/month of Methadone oral solution 5 mg/5 mL, D) 450 mL/month of Methadone oral solution 10 mg/5 mL, E) 40 mL (2 multidose vials) of Methadone 200 mg/20 mL injection, F) 90 mL/month of Methadone Intensol (10 mg/mL) solution?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
10. Does the patient require use of MORE than 60 capsules/month of Avinza 30 mg, 45 mg, 60 mg, 75 mg, 90 mg OR 30 capsules/month of Avinza 120 mg?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	
11. Does the patient require use of MORE than 90 films/month of Belbuca 75 mcg, 150 mcg, 300 mcg, 450 mcg OR MORE than 60 films/month of Belbuca 600 mcg, 750 mcg, 900 mcg?	<input type="checkbox"/> Y <input type="checkbox"/> N
[No further questions.]	

12. Does the patient require use of MORE than 8 patches/month of Butrans 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr OR MORE than 4 patches/month of Butrans 15 mcg/hr, 20 mcg/hr?	<input type="text" value="Y N"/>
[No further questions.]	
13. Does the patient require use of MORE than 60 units/month of Conzip 100 mg, tramadol ER 100 mg, 150 mg, or Ultram ER 100 mg, OR 30 units/month of Conzip 200 mg, 300 mg, or tramadol ER 200 mg, 300 mg, or Ultram ER 200 mg, 300 mg?	<input type="text" value="Y N"/>
[No further questions.]	
14. Does the patient require use of MORE than 20 patches/month of Duragesic 12 mcg, 25 mcg, 37.5 mcg OR MORE than 10 patches/month of Duragesic 50 mcg, 62.5 mcg, 75 mcg, 87.5 mcg, 100 mcg?	<input type="text" value="Y N"/>
[No further questions.]	
15. Does the patient require use of MORE than 90 capsules/month of Embeda 20/0.8 mg, 30/1.2 mg OR MORE than 60 capsules/month of Embeda 50/2 mg, 60/2.4 mg, 80/3.2 mg, 100/4 mg?	<input type="text" value="Y N"/>
[No further questions.]	
16. Does the patient require use of MORE than 60 tablets/month of Exalgo 8 mg, 12 mg, 16 mg OR MORE than 30 tablets/month of Exalgo 32 mg?	<input type="text" value="Y N"/>
[No further questions.]	
17. Does the patient require use of MORE than any of the following: A) 90 capsules/month of Kadian 10 mg, 20 mg, 30 mg, 40 mg, B) 60 capsules/month of Kadian 50 mg, 60 mg, 70 mg, 80 mg, 100 mg, C) 30 capsules/month of Kadian 130 mg, 150 mg, 200 mg?	<input type="text" value="Y N"/>
[No further questions.]	
18. Does the patient require use of MORE than any of the following: A) 90 tablets/month of Arymo ER 60 mg or MorphaBond 15 mg, 30 mg or MS Contin 60 mg, B) 120 tablets/month of Arymo ER 15 mg, 30 mg or MS Contin 15 mg, 30 mg, C) 60 tablets/month of MorphaBond 60 mg, 100 mg or MS Contin 100 mg, 200 mg?	<input type="text" value="Y N"/>
[No further questions.]	
19. Does the patient require use of MORE than 90 tablets/month of Nucynta ER 50 mg, 100 mg, 150 mg OR MORE than 60 tablets/month of Nucynta ER 200 mg, 250 mg?	<input type="text" value="Y N"/>
[No further questions.]	
20. Does the patient require use of MORE than 90 tablets/month of Opana ER 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, OR 60 tablets/month of Opana ER, 30 mg, 40 mg?	<input type="text" value="Y N"/>
[No further questions.]	

21. Does the patient require use of MORE than 90 tablets/month of OxyContin 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, OR 60 tablets/month of OxyContin 60 mg, 80 mg?	Y N
[No further questions.]	
22. Does the patient require use of MORE than 90 tablets/month of Targiniq ER 10 mg/5 mg, 20 mg/10 mg OR 60 tablets/month of Targiniq ER 40 mg/20 mg?	Y N
[No further questions.]	
23. Does the patient require use of MORE than 90 capsules/month of Xtampza ER?	Y N
[No further questions.]	
24. Does the patient require use of MORE than 90 capsules/month of Troxyca ER 10 mg/1.2 mg, 20 mg/2.4 mg, 30 mg/3.6 mg, 40 mg/4.8 mg OR 60 capsules/month of Troxyca ER 60 mg/7.2 mg, 80 mg/9.6 mg?	Y N

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

<b>Prescriber (Or Authorized) Signature and Date</b>