PRIOR AUTHORIZATION REQUEST FORM

EOC ID:
Opioid Products (Quantity Limits)

SERVE YOU Rx

Phone: 800-759-3203 Fax back to: 800-480-4840

Serve You Rx manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Plan Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty:	

Drug Name and Strength: ☐ Urgent Review Requested

Directions:

Expected Duration of Therapy:

If this is a continuation of therapy, provide start date:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please indicate what best describes the patient's history of opioid therapy:

☐ New to Therapy

☐ Treatment-Experienced (defined as having received an opioid prescription within the previous 120 days)

Q2. Is the patient receiving opioids for the management of cancer-related pain? (If yes, no need to answer any additional questions.)

☐ Yes ☐ No

Q3. Is the patient receiving opioids as part of end-of-life care (ie, hospice)? (If yes, no need to answer any additional questions.)

☐ Yes ☐ No

Q4. Please indicate the diagnosis for use:

Q5. Please provide expected duration of treatment:

Q6. Is the medication prescribed by or in consultation with a pain specialist?

☐ Yes ☐ No

Q7. Is an active treatment plan in place for the patient that includes but is not limited to a specific treatment objective and the use of other pharmacological and non-pharmacological agents for pain relief, as appropriate?

☐ Yes ☐ No

Q8. Please describe the treatment plan:

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Q9. Has the patient signed an informed consent document and has an addiction risk asessment been performed?

☐ Yes ☐ No

Q10. Has an agreement been written/signed between the prescriber and patient that address the issues of prescription management, diversion, and the use of other substances?

☐ Yes ☐ No

Q11. Additional comments:

Prescriber Signature

Date

Certain prescription benefit plans or situations may require additional information or clarification to evaluate a prior authorization request. For complete details about benefits, limitations, conditions and exclusions, please refer to the applicable plan.