BlueCross BlueShield of North Carolina | HealthyBlue

Long-Acting Opioid Analgesic Prior Authorization Form

Member Information		
1. Member last name:	2. Member first name:	
3. Member ID #:	4. Member date of birth:	5. Member gender:
Prescriber Information		
6. Prescribing provider NPI#:		
7. Requester contact information		
Name:		
Phone:	Ext:	
Drug Information		
8. Drug name:	9. Strength:	
10. Quantity per 30 days:		
11. Length of therapy (in days): ☐ up to 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days ☐ Other:		
Clinical Information		
1. Does the member have a diagnosis of malignant cancer or pain due to neoplasm? ☐ Yes ☐ No **If yes, the member is exempt from the prior authorization requirement.**		
2. Does the member have a diagnosis of chronic pain syndrome of at least four weeks duration? ☐ Yes ☐ No		
3. Is the requested daily dose *in combination with other concurrent opioids* less than or equal to 90mg of morphine or an equivalent dose? ☐ Yes ☐ No		
Answer questions 3a and 3b when the response to question 3 is 'No'.		
3a. Please supply the member's diagnosis and reason for exceeding dose per day limits.		
Please list:		
3b. Please provide the duration (days supply) the member will exceed the limit of 90mg of morphine or an equivalent dose.		
Please list:		
4. Is this an initial authorization request? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request. ☐ Yes ☐ No		
4a. If Yes, has the member tried a short-acting Opioid Analgesic in the past 45 days? ☐ Yes ☐ No		
4b. If no, explain:		
5. Has the prescriber reviewed and is adhering to the N.C. Medical Board statement on the use of controlled substances for the treatment of pain? ☐ Yes ☐ No		
6. Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete member evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate? ☐ Yes ☐ No		
7. Has the prescribing physician checked the member's utilization of controlled substances on the NC Controlled Substance Reporting System? ☐ Yes ☐ No		
8. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? ☐ Yes ☐ No		
Non-Preferred Products:		

https://provider.healthybluenc.com

BNCPEC-0273-21 May 2021

9. Does the member have a documented history within the past year of two preferred long-acting Opioid Analgesics at a dose equal to or equivalent to the non-preferred long-acting Opioid Analgesic being prescribed? ☐ Yes ☐ No	
Please list:	
10. Does the member have a contraindication or allergy to ingredients in the preferred product? ☐ Yes ☐ No	
Please list:	
Signature of prescriber:	Date:
(Prescriber signature mandatory) I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.	

Fax this form to **844-376-2318**
Healthy Blue Pharmacy PA Call Center: **844-594-5072**