BlueCross BlueShield of North Carolina | HealthyBlue

Short-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 ☐ 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 Sickle Cell Disease? ☐ Yes ☐ No		
3. Is this an initial authorization request? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request. ☐ Yes ☐ No		
3a. **If No, please attach documentation as to why the member needs continued opioid treatment and current plan of care.**		
4. 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 4a and 4b when the response to question 4 is 'No'.**		
4a. Please supply the member's diagnosis and reason for exceeding dose per day limits.		
Please list:		
4b. Please provide the duration (days supply) the member will exceed the limit of 90mg of morphine or an equivalent dose.		
Please list:		
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:		
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:		

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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**