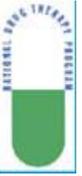




Chronic Opioid Prior Authorization Form

The info requested in this form, although extensive, is based on best practice standards and the CDC Chronic Pain Opioid Guidelines. It is intended to facilitate the safe and effective treatment, improve outcomes, and reduce adverse events including opioid use disorder and/or overdose.

WVU School of Pharmacy
 PO Box 9511 HSCN
 Morgantown, WV 26506
 Phone: 1-800-847-3859
Fax: 1-800-531-7787



Date:		Diagnosis:					
Requested Medication(s)							
Medication	Strength	Directions for use	Quantity requested per 30 days				
			30	60	90	120	Other: _____
			30	60	90	120	Other: _____
			30	60	90	120	Other: _____
Patient Information							
Patient's Last Name:		First:	Middle:	Member ID Number:		Date of Birth:	
Street Address:			City:				
State:	Zip Code:	Sex:	M	F	Race/Ethnicity:		
Prescriber Information							
Prescriber's Last Name:		First:	Middle:	Prescriber's NPI #:	Prescriber's DEA #:		
Prescriber's Specialty:			I certify that I have not charged cash for this office visit or for the treatment of this patient's pain management Yes No				
Street Address:			City:				
State:	Zip:	Phone Number:		Fax Number:			
Pharmacy Information							
Pharmacy Name:			Phone Number:				
Medical Information							
Please attach or list patient's current complete treatment list with the medical condition being treated included for each (i.e., Non-Pharmacological, Prescriptions, OTCs, Herbals, Supplements, & Illicit Substances)							
<u>Current treatments</u>			<u>Previously failed pain treatments of any/all types</u>				
Is the patient pregnant?						Yes No	
Is the patient allergic to any opioid medications? (If Yes, please list and describe reactions in 2 to 3 words)						Yes No	
Does the patient have normal renal and hepatic function? (If No, please attach glomerular filtration rate (GFR), creatinine clearance (CrCl), and/or hepatic panel lab results)						Yes No	

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Vital signs:					
Height:	Weight:	Blood Pressure:	Heart Rate:	Respiratory Rate:	
Physical exam findings relevant to pain diagnosis (Please briefly describe):					
Laboratory findings relevant to pain diagnosis (Please attach and/or briefly describe):					
Radiological findings (MRI, X-Ray, or Ultrasound) relevant to the pain diagnosis (Please briefly describe):					
Has the patient experienced a decrease in his/her daily function (i.e. ability to climb stairs, complete house work, perform tasks, etc.) beyond a subjective increase in daily pain?				Yes	No
Has the patient been screened for risk of substance-use disorder? (Please indicate risk screening tool, result, and attach)				Yes	No
Opioid Risk Tool (ORT)		Current Opioid Misuse Measure (COMM)			
Drug Abuse Screening Test (DAST)		Prescription Drug Use Questionnaire (PDUQ)			
Diagnosis, Intractability, Risk, & Efficacy Score (DIRE)		Pain Medication Questionnaire (PMQ)			
Screener & Opioid Assessment for Patients with Pain-Revised (SOAPP-R)					
What was the patient's risk of substance abuse based on the above screening tool?			Low	Moderate	High
<i>(Note: Screening for risk of substance-use disorder is required at baseline and to be updated at least every two years thereafter)</i>					
Does the patient currently have an up-to-date & signed Patient & Provider Agreement (Please attach) including:				Yes	No
<ul style="list-style-type: none"> • Therapeutic goals of reducing pain and improving functional outcomes • Treatment time frame with a planned end point as appropriate • Review of the associated risks of opioid therapy 					
<i>(Note: A Patient & Provider Agreement is required at baseline and to be updated at least every two years thereafter)</i>					
Has the patient been educated on the proper storage/disposal of controlled substances?				Yes	No
Patient's opioid daily dose is > 50 MME/day. The CDC Opioid guidelines recommend education & utilization of naloxone.					
Has the patient been educated on being a candidate for carrying naloxone?				Yes	No
Has the patient been prescribed naloxone?				Yes	No
WV Code §60A-9-5a requires initial and at least annual review of the Prescription Drug Monitoring Program (PDMP). Has the PDMP been reviewed immediately prior to the prescribing of the requested opioid medication? (If any unexpected results existed, please attach a copy to this request or briefly explain)				Yes	No
<i>This confirmatory information will be shared with the WV PDMP administration.</i>					
Has a Urine Drug Screening been completed prior to the prescribing of the requested opioid medication?				Yes	No
Were the results consistent with current treatment and devoid of illicit substance? (Please submit results with each request)				Yes	No
<i>(Note: Urine drug screening is required at baseline and to be updated annually unless more frequent testing is warranted)</i>					
Practitioner Signature: _____			Date _____		
<small>(If a signature stamp is used, then the prescribing practitioner must initial the signature, signatures by agents of the practitioner are not acceptable)</small>					

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