COMMUNITY HEALTH PLANS

Chorus Community Health Plans

Long-Acting and Short-Acting Opioid Analgesics Prior Authorization Form
IF THIS IS AN URGENT REQUEST, please call Chorus Community Health Plans Pharmacy Services.

Otherwise please return completed form to: Chorus Community Health Plans Pharmacy Services
Phone: 844-201-4677 Fax: 844-201-4675

PLEASE TYPE OR PRINT NEATLY
Incomplete responses may delay this request.

Office contact:		**Provider specialty:**	
Provider first name:		**Provider last name:**	
Provider phone #:	**Provider fax #:**	**Provider NPI #:**	
Patient name:	**CCHP Member ID #:**	**Patient DOB:**	**Patient age:**

Please provide member's weight (include units):

Drug requested: Brand Generic	**Strength:**	**Frequency:**	**Quantity dispensed (including units):**

Generic equivalent drugs will be substituted for brand name drugs unless you specifically indicate otherwise.

New medication Ongoing medication	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	Yes No

Please indicate below the member's CURRENT complete pain management treatment regimen:

Medication Name	Medication Strength	Medication Frequency

Please complete the following for an INITIAL authorization request

Please indicate the member's diagnosis/diagnoses:
☐ Cancer ☐ Sickle Cell ☐ Other: ________________________________

Is the requested medication being prescribed as part of palliative/end of life care? ☐Yes ☐ No

Please indicate anticipated duration of therapy:

Please indicate plan for taper/discontinuation:

Has the member previously tried and failed the following? If yes, please provide information below.
☐ **Medications**
☐ **Non-medication therapies (i.e. exercise therapy, physical therapy, behavioral therapy, cognitive therapy)**

Medication/Therapy Name	Medication/Therapy Name	Response or reason for discontinuation

For long-acting opioid requests, please provide rationale for using a long-acting agent:

Will the member be monitored for ongoing opioid therapy? ☐Yes ☐ No

Will the member be using non-pharmacological and non-opioid therapies in combination with opioid treatment?
☐Yes ☐ No

Please be sure to complete and include the 2nd page of this form.

Long-Acting and Short-Acting Opioid Analgesics

Patient Name:	**Patient ID Number:**	**Patient DOB:**

Please be sure to complete and include the 1st page of this form.

Was a pain assessment tool completed confirming severe pain for duration of 3 months? ☐Yes ☐ No

Was the member assessed for potential risk for opioid related harm and have strategies been considered to prevent opioid-related harm (such as naloxone)? ☐Yes ☐ No

Has the member been educated on potential adverse effects including the risk of misuse, abuse, and addiction? ☐Yes ☐ No

Has the member been educated on known risks and the realistic benefits of therapy? ☐Yes ☐ No

Did the member have a recent urine drug screen prior to starting therapy? ☐Yes ☐ No

Has the member been assessed recently (i.e. within the past 60 days) for continued use of opioid therapy? ☐Yes ☐ No

Is the member currently taking a benzodiazepine and/or other chronic opioids? ☐Yes ☐ No
If yes, please provide rationale for concurrent use or discontinuation/taper plan for benzodiazepines or other chronic opioids:
☐ Concurrent use: ______________________________
☐ Taper/discontinuation plan: ______________________________

Was the Wisconsin Prescription Drug Monitoring Program reviewed? ☐Yes ☐ No

Please complete the following for a REAUTHORIZATION request

Please provide documentation showing improved pain control and improved level of functioning.
Documentation enclosed: ☐Yes ☐ No

Please provide rationale for continued use or plan for taper/discontinuation.
☐ Continued use: ______________________________
☐ Taper/discontinuation plan: ______________________________

Will the member continue to be monitored for ongoing opioid therapy? ☐Yes ☐ No

Will the member be using non-pharmacological and non-opioid therapies in combination with opioid treatment?
☐Yes ☐ No

Is the member being followed for opioid-related adverse effects and warning signs for overdose/opioid use disorder?
☐Yes ☐ No

Was the member assessed for potential risk for opioid related harm and have strategies been considered to prevent opioid-related harm (such as naloxone)? ☐Yes ☐ No

Has the member had a recent urine drug screen? ☐Yes ☐ No

Is the member currently taking a benzodiazepine and/or other chronic opioids? ☐Yes ☐ No
If yes, please provide rationale for concurrent use or discontinuation/taper plan for benzodiazepines or other chronic opioids:
☐ Concurrent use: ______________________________
☐ Taper/discontinuation plan: ______________________________

Was the Wisconsin Prescription Drug Monitoring Program reviewed? ☐Yes ☐ No

Please provide any additional information in the space below.