MedStar Family Choice

Fax completed form to MFC MD 1-888-243-1790 or 410-933-2274

ANALGESIC OPIOID PRIOR AUTHORIZATION FORM

Patient's Information:

NAME: _____ DOB: _____

SEX: ❑ M ❑ **F**

Prescriber's Information: **Name of Facility/Clinic:** _____

NAME: _____ NPI # _____

Phone # _____ Fax # _____

Contact Person for this Request:

NAME: _____ Phone: _____ Fax: _____

**** Prior authorization is approved for 6 months only****
□ New Prescription □ Refill (Patient has been taking this medication)

Please check the appropriate box for the Opioid Prior Authorization request.
□ Quantity Limit □ High Dose □ Long-Acting Opioid □ Non-Preferred
□ Methadone for Pain □ Fentanyl □ Other_____

Use a separate form for EACH medication request:
Medication: _____ Strength: _____ Quantity: _____

SIG: _____ Length of Treatment _____ months

Clinical Consideration:

Y	N	
❑	❑	Patient receiving opioid due to cancer treatment. Cancer type:_____
❑	❑	Patient receiving opioid due to sickle cell disease.
❑	❑	The patient is in hospice or is receiving palliative care.
❑	❑	Patient is Pregnant (where applicable)
Attestation required for each of the following:		
❑		Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
❑		Patient has/will have random Urine Drug Screens.
❑		Naloxone prescription was provided or offered to patient/patient's household.
❑		Patient-Prescriber Pain Management/Opioid Treatment Agreement/Contract signed and in Medical record?

I certify that the benefits of Opioid treatment for this patient outweigh the risks of treatment.

Prescriber's Signature_____ Date_____

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