



Exceeding Morphine Milligram Equivalent (MME) Maximums Prior Authorization Request Form (Page 1 of 2)

Note: If the following information is NOT filled in completely, correctly, or legibly the PA process **may** be delayed.
Please complete one form per member.

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information <small>(required)</small>					
Please check all that apply and provide all applicable information.					
<p>Section A: If the member meets one of the following then Section B is not required</p> <p>Select if the member is receiving opioid for the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Active cancer treatment. Cancer type: _____ <input type="checkbox"/> Hospice. Diagnosis: _____ <input type="checkbox"/> Long-term care/skilled nursing facility <input type="checkbox"/> Palliative care (diagnosis code Z51.5). Diagnosis: _____ <input type="checkbox"/> Sickle cell disease 					
<p>Section B: For members not meeting one of the criteria under Section A</p> <p>Does the member have a diagnosis requiring around-the-clock pain management? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Provide the diagnosis: _____</p> <p>Has the provider reviewed controlled substance prescriptions in the prescription drug monitoring program? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please select and provide the pain management specialist's information below:*</p> <ul style="list-style-type: none"> <input type="checkbox"/> Regimen prescribed by a pain management specialist within last 6 months Specialist's name: _____ Date of last visit: _____ <input type="checkbox"/> Regimen prescribed in consultation with a pain management specialist within last 6 months Specialist's name: _____ Date of last consultation: _____ <p><i>*Please note: Physician must be Board Certified by one of the following:</i></p> <ol style="list-style-type: none"> 1. American Board of Anesthesiology-Pain Management 2. American Board of Psychiatry & Neurology-Pain Management 3. American Board of Physical Medicine & Rehabilitation 4. American Osteopathic Association-Pain Management <p>Is the member-prescriber pain management/opioid agreement/contract signed within one year of request and is in medical record? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
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Please select dose attestation:

- Dose reduction is planned
- Dose reduction has occurred since previous prior approval.

Previous Dose: _____

New Dose: _____

- There is documentation of an attempted unsuccessful dose taper within the past 6 months.

Taper Date: _____

- Provider attests that a dose taper is not clinically appropriate for this member

Has or will the member have random urine drug screens? Yes No

Was naloxone prescription provided or offered to member/member's household? Yes No

I certify that the benefits of opioid treatment for this member outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Physician Signature (required): _____ Date: _____

Physician Office Contact Person: _____ Phone: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-866-525-5827.
This form may be used for non-urgent requests and faxed to 1-877-239-4565.