OHIO DEPARTMENT OF MEDICAID

REQUEST FOR RX PRIOR AUTHORIZATION
SHORT-ACTING OR LONG-ACTING OPIOID MEDICATION

Request Date		Review Type Requested ☑ Standard ☐ Urgent	
Individual's Full Name		Prescriber's Full Name	
Individual's Date of Birth		Prescriber's DEA Number	
Individual's Medicaid ID Number		Prescriber's NPI Number	
Age	Height	Prescriber's Address	
Weight	Sex	Prescriber's Phone Number	Prescriber's Fax Number
(If Known) Pharmacy's Name		Pharmacy's Phone Number	
Drug Requested	Strength	Route	
Frequency	Duration of Therapy	Quantity	☐ New ☐ Renewal
Diagnosis andICD-10 code **(MUST BE INCLUDED TO AVOID DELAYS)**			
Check all that apply: ☐ active cancer ☐ palliative care ☐ hospice care ☐ sickle cell ☐ severe burn ☐ traumatic crushing of tissue ☐ amputation ☐ major orthopedic surgery			

*If any of these diagnoses are checked the remaining questions need **not** be completed*

List non-pharmacologic treatment(s) tried/explanation if none tried *(i.e. physical therapy)*
List non-opioid analgesics tried/explanation if none tried *(i.e. NSAIDs)*
Concurrent therapies
Additional significant information for requesting a non-preferred drug *(i.e. allergy, contraindications, drug-drug interactions, lab results, etc.)*

For Short-Acting Opioid Request

Has prescriber reviewed the OARRS?	☐ Yes ☐ No
Is individual opioid naïve?	☐ Yes ☐ No
For dose exceeding 30 MED per day please provide explanation	
For days' supply exceeding 7 days please provide explanation	
Has the prescriber discussed benefits and risks of opioid therapy with the individual?	☐ Yes ☐ No

For Long-Acting Opioid Request

New Start: REQUIRED documents to be submitted *(NOT required for cancer pain or catastrophic injury)*

- Risk assessment plan
- Substance abuse history
- Pain & function scores at each visit
- Opioid contract
- Baseline & random UDS

Has prescriber reviewed the OARRS within 7 Days prior to the prior authorization request?	☐ Yes ☐ No
Has individual tried short-acting opioids for >/= 60 days?	☐ Yes ☐ No
Is the cumulative dose </= 80 MED?	☐ Yes ☐ No

Renewal Request: REQUIRED documents to be submitted

- Demonstrated adherence to treatment plan with NO serious adverse outcomes *(pain & function scores, UDS, progress notes)*
- Current treatment plan

For Dose Escalation Request

Rationale	
Is cumulative dose >100 MED? ☐ Yes ☐ No	**IF YES**, has there been a consultation with pain specialist or anesthesiologist? ☐ Yes ☐ No

☐ I attest that I am a member of the prescriber's staff in accordance with Ohio Administrative Code 5160-9-03, as applicable. Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

_____ _____

Prescriber's Signature (or staff of prescriber) Date

_____

IF a staff member is attesting, please print your name

Fax To: Ohio Department of Medicaid
Fax: (800) 396-4111 PA Helpdesk: (877) 518-1546
Hours: Monday – Friday 8:00 am – 8:00 pm EST