

OHIO DEPARTMENT OF MEDICAID
Request for Rx Prior Authorization
Short-Acting or Long-Acting Opioid Medication

Request Date		
Patient Medicaid ID Number		Prescriber's Full Name
Patient DOB		NPI Number
Patient's Full Name		DEA Number
Age	Height	Prescribers Phone Number
Weight	Sex	Prescribers Fax Number
Pharmacy Name		Pharmacy Phone Number
Pharmacy Fax Number		Provider Number
Drug and Strength Requested		Quantity Day Supply
Directions		
Diagnosis and/or ICD-10 code (MUST BE INCLUDED TO AVOID DELAYS)		

Please check if the patient is being treated for

<input type="checkbox"/> Active Cancer	<input type="checkbox"/> Severe Burn	<input type="checkbox"/> Sickle Cell
<input type="checkbox"/> Palliative Care	<input type="checkbox"/> Traumatic crushing of tissue	<input type="checkbox"/> Major Orthopedic Surgery
<input type="checkbox"/> End of life/hospice	<input type="checkbox"/> Amputation	

*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>i.e. physical therapy</i>)
List non-opioid analgesics tried/explanation if none tried (<i>i.e. NSAIDs</i>)
Concurrent therapies

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

For Short-Acting Opioid Request

Has prescriber reviewed the OARRS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is patient opioid naïve?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For dose exceeding 30 MED per prescription please provide explanation	
For day supply exceeding 7 days please provide explanation	
Benefits and risks of opioid therapy discussed with patient?	<input type="checkbox"/> Yes <input type="checkbox"/> No

For Long-Acting Opioid Request

New Start: REQUIRED documents to be submitted (<i>NOT required for cancer pain or catastrophic injury</i>) <ul style="list-style-type: none">▪ Risk assessment plan▪ Substance abuse history▪ Pain & function scores at each visit▪ Opioid contract▪ Baseline & random UDA	
Has prescriber reviewed the OARRS within 7 Days prior to the prior authorization request?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has patient tried short-acting opioids for ≥ 60 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the cumulative dose ≤ 80 MED?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Renewal Request: REQUIRED documents to be submitted	
<ul style="list-style-type: none">▪ Current treatment plan▪ Demonstrated adherence to treatment plan with NO serious adverse outcomes (<i>pain & function scores, UDA, progress notes</i>)	
Dose escalation request	
Rationale	
Is cumulative dose >100 MED? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF YES , has there been a consultation with pain specialist or anesthesiologist?
Additional significant information for requesting a non-preferred drug (<i>i.e. allergy, contraindications, drug-drug interactions, lab results, etc.</i>)	

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

Prescriber's Signature (or staff of prescriber & PRINTED name)

Date