PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

OxyContin® and oxycodone controlled-release (CR) Long-Acting Opioid Prior Authorization Request Form (Page 1 of 4)

Member Information (required)			Provider Information (required)		
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 (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

For states, such as AR, that have a terminal illness mandate, and for patients who have a terminal illness, please answer the following:

Will the requested medication be used for the treatment of a terminal condition or associated symptoms? ❑ **Yes** ❑ **No**
If "**YES**", please indicate the patient's estimated life expectancy: ❑ Less than 6 months ❑ Less than_____months (please specify)

Select all the applicable diagnoses below :

❑ Cancer or end of life related pain
❑ Moderate to severe chronic pain that is non-neuropathic
❑ Moderate to severe neuropathic pain or fibromyalgia (examples of neuropathic pain include neuralgias, neuropathies)
❑ Other diagnosis: _____

For diagnosis of cancer or end of life (defined as a < 2 years life expectancy) related pain, please answer the following:

Does the patient have an active cancer diagnosis or life expectancy of < 2 years? ❑ **Yes** ❑ **No**

Will medical records documenting an active cancer diagnosis or life expectancy of < 2 years be submitted to *ProAct*® with this fax form? ❑ **Yes** ❑ **No**

****Please note: Medical records documenting an active cancer diagnosis or life expectancy of < 2 years is required to be submitted along with this fax form. ****

For diagnosis of moderate to severe chronic pain that is non-neuropathic, please answer the following:

Is the requested medication being used as an as-needed (PRN) analgesic? ❑ **Yes** ❑ **No**

Is the requested medication being used for pain that is mild or not expected to persist for an extended period of time? ❑ **Yes** ❑ **No**

Is the requested medication being used for acute pain? ❑ **Yes** ❑ **No**

Is the requested medication being used for postoperative pain? ❑ **Yes** ❑ **No** If **yes**, please answer the following:

- Has the patient already received chronic opioid therapy prior to surgery or is the postoperative pain expected to be moderate to severe and persist for an extended period of time? ❑ **Yes** ❑ **No**

Prior to the start of therapy with the requested long-acting opioid, has the patient failed an adequate trial of a short-acting opioid? ❑ **Yes** ❑ **No**

If **yes**, please document the name of the medication(s), date, and duration of trial:

Medication:_____ Date of trial:_____ Duration of trial: _____

For diagnosis of moderate to severe neuropathic pain or fibromyalgia, please answer the following:

Does the patient have a contraindication to or has not exhibited an adequate response to treatment with gabapentin titrated to a therapeutic dose? ❑ **Yes** ❑ **No** If **yes**, please document dose, date, and duration of trial

Dose:_____ Date of trial:_____ Duration of trial: _____

Does the patient have a contraindication to or has not exhibited an adequate response to treatment with a tricyclic antidepressant titrated to the maximum tolerated dose? ❑ **Yes** ❑ **No** If **yes**, please document drug, dose, date, and duration of trial:

Medication:_____Dose:_____ Date of trial:_____ Duration of trial: _____

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Select the medications the patient has a history of failure, contraindication, or intolerance to (Document date and duration of trials):

- ❑ Fentanyl transdermal patch (generic Duragesic) Date:_____ Duration of trial: _____
- ❑ Morphine sulfate controlled-release tablet (generic MS Contin) Date:_____ Duration of trial: _____
- ❑ Nucynta ER Date:_____ Duration of trial: _____
- ❑ Xtampza ER Date:_____ Duration of trial: _____

Please also answer the following:
Does the patient require more than 320 mg/day of controlled-release oxycodone? ❑ **Yes** ❑ **No**

Reauthorization [Non-cancer and non-end of life pain only]:
If this is a reauthorization request, please answer all of the following questions:

1. What are the treatment goals for this patient? (Document treatment goals) _____
2. What alternative nonopioid analgesic and/or nonpharmacologic interventions are currently being used with this requested medication? (Document other treatment interventions) _____
3. Has the patient demonstrated meaningful improvement in pain scale score? (Document score) ❑ **Yes** ❑ **No** _____
4. What is the patient's most recent score on a substance abuse/opioid dependence risk assessment tool? (Document score) _____
5. What is the rationale for not tapering and discontinuing the requested medication? (Document rationale) _____
6. What comorbid mental health conditions has the patient been screened for? (Document mental health conditions for which the patient has been screened) _____
7. Has the state's prescription drug monitoring program (PDMP) been reviewed for this patient? ❑ **Yes** ❑ **No** ❑ **None in state**
   What other controlled substances is the patient currently receiving? _____
8. Has the patient been assessed for risk of respiratory depression from medical comorbidities or the concurrent use of benzodiazepines or other drugs causing drug-drug interactions and the prescriber acknowledges that they have completed an assessment of increased risk for respiratory depression? ❑ **Yes** ❑ **No** _____
9. What is the patient's total daily dose? _____

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Quantity limit requests:

What is the quantity requested per DAY? _____

For diagnosis of cancer related pain or who are end of life (life expectancy < 2 years), please answer the following:

Can the requested dose be achieved by moving to a higher strength dosage form? ❑ **Yes** ❑ **No**

For diagnosis of non-cancer or non-end of life related pain, please answer the following:

Does the requested dose exceed 90 morphine equivalent doses (MED) daily? ❑ **Yes** ❑ **No**

Example of 90 MED equivalent: Oxycontin & oxycodone CR = 60mg/day

Can the requested dose be achieved by moving to a higher strength dosage form? ❑ **Yes** ❑ **No**

Was the requested medication prescribed by a pain specialist or by pain management consultation? ❑ **Yes** ❑ **No**

Select all of the following that have been maintained and documented in chart notes*:

❑ A description of the nature and intensity of the pain
❑ An appropriate patient medical history and physical examination
❑ An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
❑ Appropriate dose escalation
❑ Ongoing, periodic review of the course of opioid therapy
❑ Verification that the risks and benefits of the use of the requested drug have been discussed with the patient, significant other(s), and/or guardian

***Chart documentation:**

Will chart documentation be submitted to *ProAct*® with this form, confirming the above information? ❑ **Yes** ❑ **No**

***Please note: Chart documentation of the above is required to be submitted along with this fax form.*

Prescriber attestation:

Does the prescriber attest that the information provided is true and accurate to the best of their knowledge and understand that Proact may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided?
❑ **Yes** ❑**No**

Prescriber's signature:_____ Date: _____

Please note: All information must be completed and chart documentation (i.e., chart notes) [w here applicable] must be submitted to ProAct.

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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

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I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	