OPIOID/BENZODIAZEPINE/PAIN THERAPY
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the provider may complete this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/star_kids_prior_auth.html

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	
BCBS ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description**:**

Medication Requested: Strength: Length of Therapy:

Dosing Schedule: Quantity per Month:

1. Is the patient currently treated with the requested medication? ☐ Yes ☐ No
   If yes, when was treatment with the requested medication started? _____
2. Does the patient have a diagnosis of chronic cancer pain due to an active malignancy? ☐ Yes ☐ No
3. Is the patient eligible for hospice care? ☐ Yes ☐ No
4. Is the requested medication a benzodiazepine that will be taken concurrently with an opioid? ☐ Yes ☐ No
   If no, is the requested medication an opioid that will be taken concurrently with a benzodiazepine? ☐ Yes ☐ No
5. Is the prescriber a specialist or have they consulted with one in any of the following (Check all that apply)? ☐ Yes ☐ No
   ☐ Pain Specialist ☐ Neurologist ☐ Behavioral Health Specialist
6. Will the benzodiazepine or opioid medication be discontinued within no more than 2 months? ☐ Yes ☐ No
   If no, please explain: _____
   What is the requested duration of the concurrent use of the opioid and benzodiazepine? _____
   Will the patient be monitored during the concurrent use of the opioid and benzodiazepine agents? ☐ Yes ☐ No
7. Is the benzodiazepine being used for a psychiatric diagnosis, muscle spasms, or a convulsive disorder? ☐ Yes ☐ No
8. Please list all reasons for selecting the requested **medication, dosing schedule, and quantity** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives, lower dose tried). _____
   _____
   _____
9. Please list any other medications or non-pharmacological therapies the patient will use in **combination** with the requested medication for treatment of this diagnosis. (Please include strength and quantity per month.)
   _____ Quantity: _____ _____ Quantity: _____
   _____ Quantity: _____ _____ Quantity: _____
   _____ Quantity: _____ _____ Quantity: _____

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Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

10. Please list all medications the patient has **previously tried and failed for treatment of this diagnosis.** (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products.)

_____ Date(s): _____ _____Date(s): _____

_____ Date(s): _____ _____Date(s): _____

_____ Date(s): _____ _____Date(s): _____

11. Please list all **non-pharmacological therapy** the patient has **previously tried and failed for treatment of this diagnosis**.

_____

_____

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Please fax or mail this form to:
Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.243.6930 Phone: 855.457.1200

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