Prescriber Criteria Form

Opioids ER 2025 PA Fax 2493-A v1 010125.docx
Extended-Release Opioid Analgesics
Conzip (tramadol hydrochloride extended-release capsule), Hysingla ER (hydrocodone bitartrate extended-release tablet), Methadone 5 mg, 10 mg (methadone hydrochloride tablet), Methadone Intensol 10 mg/ml (methadone hydrochloride oral concentrate), Methadone 5 mg/5 ml 10 mg/5 ml Oral Soln (methadone hydrochloride oral solution), MS Contin (morphine sulfate extended-release tablet), Nucynta ER (tapentadol hydrochloride extended-release tablet), Oxycontin (oxycodone hydrochloride extended-release tablet), Xtampza ER (oxycodone extended-release capsule), Morphine Sulfate Extended-Release Capsule, Hydromorphone Hydrochloride Extended-Release Tablet, Hydrocodone Bitartrate Extended-Release Capsule, Oxymorphone Hydrochloride Extended-Release Tablet, Tramadol Hydrochloride Extended-Release Tablet, Levorphanol Tartrate Tablet
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-663-7673.**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Extended-Release Opioid Analgesics.

Drug Name (select from list of drugs shown):

| | | |
|---|---|---|
| **Patient Name:** | | |
| **Patient ID:** | | |
| **Patient DOB:** | **Patient Phone:** | |
| **Prescriber Name:** | | |
| **Prescriber Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Prescriber Phone:** | **Prescriber Fax:** | |
| **Diagnosis**: | **ICD Code(s):** | |

| **Please circle the appropriate answer for each question.** | | | |
|---|---|---|---|
| 1 | Is the requested drug being prescribed for pain associated with any of the following: A) cancer, B) sickle cell disease, C) a terminal condition, D) pain being managed through palliative care?<br>[If yes, then no further questions.] | Yes ◯ | No ◯ |
| 2 | Is the requested drug being prescribed for pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid?<br>[If no, then no further questions.] | Yes ◯ | No ◯ |
| 3 | Can the patient safely take the requested dose based on their history of opioid use?<br>[Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.]<br>[If no, then no further questions.] | Yes ◯ | No ◯ |

| | | | |
|---|---|---|---|
| 4 | Has the patient been evaluated, and will the patient be monitored for the development of opioid use disorder?<br>[If no, then no further questions.] | Yes ◯ | No ◯ |
| 5 | Is this request for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days?<br>[If yes, then no further questions.] | Yes ◯ | No ◯ |
| 6 | Has the patient taken an immediate-release opioid for at least one week? | Yes ◯ | No ◯ |

| | |
|---|---|
| Comments: | _____ |

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

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