Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Opioid Analgesic: Long-Acting

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
3. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. Length of Therapy: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days

Clinical Information

1. Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ☐ **Yes*** ☐ **No** ***If yes, the patient is exempt from the prior authorization requirement**
2. Does the member have a diagnosis of moderate to severe pain with need for around-the-clock analgesia for an extended period? ☐ **Yes** ☐ **No**
3. **Is the requested daily dose *in combination with other concurrent opioids* less than or equal to 90mg of morphine or an equivalent dose? ☐ Yes ☐ No****
   ****Answer questions a and b when the response to question 3 is '**No**'.
   a. Please supply the member's diagnosis and reason for exceeding dose per day limits.
      Please list: _____
   b. Please provide the duration (days supply) the member will exceed the limit of 90mg of morphine or an equivalent dose.
      Please list: _____
4. Is this an initial authorization request? **Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.** ☐ **Yes** ☐ **No**
   a. If yes, has the member tried a short-acting Opioid Analgesic in the past 45 days? ☐ **Yes** ☐ **No**
   b. If no, explain: _____
5. Has the prescriber reviewed and is adhering to the N.C. Medical Board statement on the use of controlled substances for the treatment of pain? ☐ **Yes** ☐ **No**
6. Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete member evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate? ☐ **Yes** ☐ **No**
7. Has the prescribing physician checked the member's utilization of controlled substances on the NC Controlled Substance Reporting System? ☐ **Yes** ☐ **No**
8. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? ☐ **Yes** ☐ **No**

Non-Preferred Products:

9. Does the patient have a documented history within the past year of two preferred long-acting Opioid Analgesics at a dose equal to or equivalent to the non-preferred long-acting Opioid Analgesic being prescribed? ☐ **Yes** ☐ **No**
   Please list: _____
10. Does the patient have a contraindication or allergy to ingredients in the preferred product? ☐ **Yes** ☐ **No**
    Please list: _____

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.