MedStar Family Choice

A request must be accompanied by MEDICAL RECORDS that support the medication. MFC-Maryland will approve, deny, or request supporting medical records within 24 HOURS of receipt of the request. If MFC does not receive the necessary medical records to make a determination, we may allow up to 14 calendar days to submit required clinical records. Return by fax to MedStar Family Choice-Maryland at: 410-933-2274.

ANALGESIC OPIOID PRIOR AUTHORIZATION FORM

Patient's Information:

NAME: DOB:

SEX: ❑ M ❑ **F** **MFC ID or MA number:**

Prescriber's Information: **Name of Facility/Clinic:**

NAME: NPI #

Phone # Fax #

Contact Person for this Request:

NAME: Phone: Fax:

**** Prior authorization is approved for 6 months only****
□ New Prescription □ Refill (Patient has been taking this medication)

**** Diagnosis with ICD10****_____

Please check the appropriate box for the Opioid Prior Authorization request.
□ Quantity Limit □ High Dose □ Long-Acting Opioid □ Non-Preferred
□ Methadone for Pain □ Fentanyl □ Other_____

Use a separate form for EACH medication request:
Medication:_____Strength: _____Quantity: _____

SIG: _____Length of Treatment_____months

Clinical Consideration: If "Y" please submit supporting clinical documentation to support use.

Y	N	
❑	❑	Patient receiving opioid due to cancer treatment. Cancer type:_____
❑	❑	Patient receiving opioid due to sickle cell disease.
❑	❑	The patient is in hospice or is receiving palliative care.
❑	❑	Patient is Pregnant (where applicable)
❑	❑	Is this patient being discharged from the hospital or ED?
❑	❑	Is this being prescribed by a Dentist?
❑	❑	Is the member being discharged from a post-op procedure? Type of procedure performed_____

Attestation required for each of the following:		
❑		Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
❑		Patient has/will have random Urine Drug Screens.
❑		Naloxone prescription was provided or offered to patient/patient's household.
❑		Patient-Prescriber Pain Management/Opioid Treatment Agreement/Contract signed and in Medical record?

I certify that the benefits of Opioid treatment for this patient outweigh the risks of treatment.

Prescriber's Signature_____**Date**_____

Fax completed form to 1-888-243-1790 or 410-933-2274

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