



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

**Attestation required for each of the following:**

<input type="checkbox"/>	Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
<input type="checkbox"/>	Patient has/will have random Urine Drug Screens.
<input type="checkbox"/>	Naloxone prescription was provided or offered to patient/patient's household.
<input type="checkbox"/>	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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