BlueCross BlueShield Federal Employee Program.

OPIOID POWDERS
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

*****The CDC's Opioid Guideline Mobile App is designed to help providers with Morphine Milligram Equivalent (MME) calculations when prescribing opioids. The CDC app is available for free download on Google Play for Android devices and in the Apple Store for iOS devices*****

NOTE: Form must be completed in its **entirety** for processing

Please select opioid powder: ❑**Buprenorphine Powder** ❑**Methadone Powder**

*****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Is the **prescribing physician** a board-certified oncologist? ❑Yes ❑No

2. What is the total MME per day of **ALL** opioids added together for the patient's current pain regimen? ***Please select answer below***:
   ❑**200 MME per day or less** (***specify all opioids)***: _____
   ❑**Greater than 200 MME per day** (***specify all opioids)***: _____

3. Which dosage form will the powder be compounded into? ***Please select dosage form below:***
   ❑Injection ❑Nasal spray ❑Oral (capsule/suspension/tablet) ❑Suppository ❑Topical (cream/gel/ointment/patch/solution)
   ❑Other dosage form ***(please specify)***: _____

4. Is the requested dose commercially available? ❑Yes ❑No

5. Does the requested dose exceed the 90 MME for the requested ingredient? ❑Yes ❑No

6. What is the final dose/strength being requested? _____

7. What is the patient's diagnosis?
   ❑Opioid addiction **OR** ❑Opioid dependence
   a. Will the patient be receiving counseling and psychosocial support? ❑Yes ❑No
   b. Will the patient be monitored during therapy for signs and symptoms of abuse and/or misuse as well as compliance and the potential diversion to others? ❑Yes ❑No
   c. Is this medication being used exclusively for pain control? ❑Yes ❑No
   d. Will the patient be receiving other opioids? ❑Yes***** ❑No
      ****If YES***, will the patient be tapered off the other opioids within 30 days? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Pain

a. Which level of pain is the patient being treated for? ❑Mild ❑Moderate ❑Moderate to severe ❑Severe

b. Have alternative treatments, including non-opioid analgesics and opioid immediate-release analgesics, been ineffective, not tolerated, or inadequate at controlling the patient's pain? ❑Yes ❑No

c. Does the prescriber agree to assess the patient for the benefits of the pain control, for example, by implementing a care plan, monitoring for signs of misuse/abuse using standard lab screening (i.e., urine, blood), and evaluating severity of pain after three months? ❑Yes ❑No

d. Does the prescriber agree to assess the patient for signs and symptoms of serotonin syndrome? ❑Yes ❑No

e. Does the prescriber agree to evaluate the patient's response to therapy before changing dose or adding additional opioid medications? ❑Yes ❑No

f. Will the compounded medication be used in combination with opioid addiction treatment or methadone? ❑Yes ❑No

g. Will the patient be using this medication in combination with alprazolam (Xanax), clonazepam (Klonopin), diazepam (Valium), or lorazepam (Ativan)? ❑Yes ❑No

h. Will the patient be using this medication in combination with oxazepam (Serax), chlordiazepoxide (Librium), or clorazepate dipotassium (Tranxene)? ❑Yes ❑No

i. Does the prescriber agree to participate in the ***Opioid Analgesic REMS program **AND** to monitor for abuse, misuse, addiction, and overdose and discontinue if necessary? ❑Yes ❑No

Opioid Analgesic REMS Program: **https://opioidanalgesicrems.com**

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***