



Federal Employee Program.

**OPIOID DRUGS
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: <input type="checkbox"/> Male <input type="checkbox"/> Female		Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:		State:	Zip:	City:		State: Zip:
Patient ID: R <input type="text"/>				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

Select Drug:	Brand/Generic:	Drug Strength:	Dosing Directions:
EXTENDED RELEASE (ER) OPIOIDS			
<input type="checkbox"/> Buprenorphine film	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Buprenorphine patch	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Fentanyl patch	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Hydrocodone	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Hydromorphone	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Morphine sulfate	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Morphine sulfate/naltrexone	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Oxycodone	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Oxymorphone	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Tapentadol	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Tramadol	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
IMMEDIATE RELEASE (IR) OPIOIDS			
<input type="checkbox"/> Butorphanol nasal spray	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Codeine tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Hydromorphone liquid	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Hydromorphone suppository	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Hydromorphone tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Levorphanol tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Meperidine oral solution	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Meperidine tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Morphine sulfate oral solution	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Morphine sulfate suppository	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Morphine sulfate tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Oxycodone capsule	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Oxycodone oral solution	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Oxycodone tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Oxymorphone tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Pentazocine/naloxone tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Tapentadol tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Tramadol oral solution	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Tramadol tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DRUGS AND QUESTIONS

PAGE 1 of 3



**BlueCross
BlueShield**

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PAGE 2 - PHYSICIAN COMPLETES

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

Select Drug:	Brand/Generic:	Drug Strength:	Dosing Directions:
IMMEDIATE RELEASE (IR) OPIOID COMBO			
<input type="checkbox"/> Benzhydrocodone/APAP	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Celecoxib/tramadol tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Codeine/APAP solution	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Codeine/APAP tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Dihydrocodeine/APAP/caffeine tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Hydrocodone/APAP elixir	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Hydrocodone/APAP solution	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Hydrocodone/APAP tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Hydrocodone/ibuprofen tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Oxycodone/APAP solution	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Oxycodone/APAP tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Oxycodone/ASA tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Oxycodone/ibuprofen tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Tramadol/APAP tablet	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
OPIOID POWDERS			
<input type="checkbox"/> Butorphanol Powder	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Codeine Powder	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Hydrocodone Powder	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Hydromorphone Powder	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Levorphanol Powder	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Meperidine Powder	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Morphine Powder	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Oxycodone Powder	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		
<input type="checkbox"/> Oxymorphone Powder	<input type="checkbox"/> Brand <input type="checkbox"/> Generic		

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

****Non-covered branded medications must go through prior authorization and the formulary exception process

- What is the total MME per day of ALL opioids added together for the patient's requested pain regimen? *Please select answer below:*
☐ 90 MME per day or less (specify all opioids): _____
☐ Greater than 90 MME per day (specify all opioids): _____
- Is this medication being used to treat any of the following: pain associated with cancer or prescribed by a board-certified oncologist, pain associated with sickle cell disease, **OR** treatment associated with hospice, palliative, or end-of-life care? ☐ Yes* ☐ No
**If YES, please specify which:* ☐ Pain associated with cancer or prescribed by a board-certified oncologist
☐ Pain associated with sickle cell disease
☐ Treatment associated with hospice, palliative, or end-of-life care
- Will the patient be using this medication concurrently with Lucemyra, methadone (Dolophine), or a buprenorphine medication such as Suboxone for opioid addiction? ☐ Yes* (**If YES, please select medication below*) ☐ No
☐ Buprenorphine medication for opioid addiction ☐ Lucemyra ☐ Methadone (Dolophine)
- Will the patient also be taking Fioricet with codeine (butalbital/APAP/caffeine/codeine) or Fiorinal with codeine (butalbital/aspirin/caffeine/codeine)? ☐ Yes* (**If YES, please specify which medication below*) ☐ No
☐ Fioricet with codeine (butalbital/APAP/caffeine/codeine) **OR** ☐ Fiorinal with codeine (butalbital/aspirin/caffeine/codeine)
- Is the patient being treated for pain? ☐ Yes ☐ No
- Does the prescriber agree to assess the patient for signs and symptoms of serotonin syndrome? ☐ Yes ☐ No

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL QUESTIONS

PAGE 2 of 3



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PAGE 3 - PHYSICIAN COMPLETES

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

7. 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>**

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

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

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

11. Has the patient received opioid therapy within the past 180 days? **Please select answer below:**

☐ **Yes:** Does the prescriber agree to continue to assess the patient for the benefits of 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 of therapy? ☐ Yes ☐ No

☐ **No:** Please answer the following questions:

a. 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

b. Does the prescriber agree to assess the patient for the benefits of 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 of therapy? ☐ Yes ☐ No

c. **Age 18 or Older:** In the past 180 days, has the patient been on an immediate release or extended release opioid **OR** have filled an initial 7-day supply of **ANY** immediate release opioid (this may include the requested medication)? ☐ Yes ☐ No

12. **Age 17 or younger:** In the last 180 days, has the patient filled at least a 3-day supply of **ANY** opioid (this may include the requested medication)? ☐ Yes ☐ No

13. **Age 18 or Older:** Has the patient filled at least a 10-day supply or more of **ANY** immediate release (IR) opioid in the last 180 days **OR** is switching from another long-acting (ER) opioid? ☐ Yes ☐ No

14. **Duragesic (Fentanyl) Patch Request:** Please answer the following questions:

a. Is the requested dosing regimen every 48 hours, with a total Duragesic dose less than or equal to 62.5 mcg? ☐ Yes* ☐ No

***If YES,** has the patient experienced failure, side effects, or inadequate pain control at a higher (mg) patch every 72 hours than the one being requested now? ☐ Yes ☐ No

b. Is the patient using multiple strengths? ☐ Yes ☐ No

c. How often is the patient changing this patch? **Please select answer below:**

☐ Daily (every 24 hours/QD) ☐ Every other day (every 48 hours/QOD) ☐ Every 3 days (every 72 hours/Q 72 H)

☐ Other (please specify frequency): _____

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