Trillium Health Resources
Pharmacy Prior Approval Request for

Opioid Analgesic: Short-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 (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ Other _____

Clinical Information

1. Does the member have a diagnosis of malignant cancer or pain due to neoplasm? ☐ **Yes*** ☐ **No** ***If yes, the member is exempt from the prior authorization requirement**
2. Does the member have Sickle Cell Disease? ☐ **Yes** ☐ **No**
3. Is this an initial authorization request? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
   ☐ **Yes** ☐ **No**
   a. If No, please attach documentation as to why the member needs continued opioid treatment and current plan of care.
4. **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 4 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: _____
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 member 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 member have a contraindication or allergy to ingredients in the preferred products? ☐ **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.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277