1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Demerol® (meperidine) Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderate to severe pain

❑ Other diagnosis:_____ICD-10 Code(s): _____

If the patient has End-Stage Renal Disease (ESRD), select all that apply:

❑ The medication is being used to treat one of the following: Graft site pain or pain medication overdose

❑ The dialysis provider (i.e., nephrologist, nurse practitioner, physician assistant, or dialysis center) receives a monthly capitation payment to manage the ESRD patient's care

The approval criteria is based on the guidance provided by the Centers for Medicare & Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.

Risk acknowledgment:

Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? ❑ **Yes** ❑ **No**

Does the provider wish to proceed with the originally prescribed medication? ❑ **Yes** ❑ **No**

Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Codeine sulfate	❑ Hydromorphone	❑ Opana	❑ Roxicodone
❑ Dilaudid	❑ Ibudone	❑ Oxycodone	❑ Tramadol
❑ Fentanyl patch	❑ Lorcet	❑ Oxycodone-APAP	❑ Tramadol-APAP
❑ Hycet	❑ Lorcet HD	❑ Oxycodone-aspirin	❑ Vicodin
❑ Hydrocodone-acetaminophen (APAP) 300mg	❑ Lorcet Plus	❑ Oxycodone-ibuprofen	❑ Vicodin ES
❑ Hydrocodone-APAP 325mg	❑ Morphine sulfate	❑ Oxymorphone	❑ Vicodin HP
❑ Hydrocodone-ibuprofen 5-200mg	❑ Norco	❑ Percocet	❑ Xodol
❑ Hydrocodone-ibuprofen 7.5mg-200mg	❑ Nucynta	❑ Primlev	❑ Zamicet
❑ Hydrocodone-ibuprofen10-200mg			

❑ Short-term non-steroidal anti-inflammatory drug (NSAIDS). Please specify: _____

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Quantity limit requests:
What is the quantity requested per DAY? _____
Does the patient's diagnosis include malignant (cancer) pain? ❑ **Yes** ❑ **No**
Was the medication prescribed by a pain specialist or by pain management consultation? ❑ **Yes** ❑ **No**

Select all of the following that have been maintained and documented in chart notes:
❑ A description of the nature and intensity of the pain
❑ An appropriate patient medical history and physical examination
❑ An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
❑ Appropriate dose escalation
❑ Ongoing, periodic review of the course of opioid therapy
❑ Verification that the risks and benefits of the use of the requested drug have been discussed with the patient, significant other(s), and/or guardian

Chart documentation:
Will chart documentation be submitted to *ProAct*® with this form, confirming the above information? ❑ **Yes** ❑ **No**
***Please note: Chart documentation of the above is required to be submitted for quantity limit requests for this drug.*

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	