

Exalgo® (hydromorphone extended-release [ER]) Long-Acting Opioid Prior Authorization Request Form (Page 1 of 4)

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)

For states, such as AR, that have a terminal illness mandate, and for patients who have a terminal illness, please answer the following:

Will the requested medication be used for the treatment of a terminal condition or associated symptoms? Yes No
 If "YES", please indicate the patient's estimated life expectancy: Less than 6 months Less than _____ months (please specify)

Select all the applicable diagnoses below:

Cancer or end of life related pain
 Moderate to severe chronic pain that is non-neuropathic
 Moderate to severe neuropathic pain or fibromyalgia (examples of neuropathic pain include neuralgias, neuropathies)
 Other diagnosis: _____

For diagnosis of cancer or end of life (defined as a < 2 years life expectancy) related pain, please answer the following:

Does the patient have an active cancer diagnosis or life expectancy of < 2 years? Yes No
 Will medical records documenting an active cancer diagnosis or life expectancy of < 2 years be submitted to ProAct® with this fax form?
 Yes No
 ***Please note: Medical records documenting an active cancer diagnosis or life expectancy of < 2 years is required to be submitted along with this fax form. ***

For diagnosis of moderate to severe chronic pain that is non-neuropathic, please answer the following:

Is the requested medication being used as an as-needed (PRN) analgesic? Yes No
 Is the requested medication being used for pain that is mild or not expected to persist for an extended period of time? Yes No
 Is the requested medication being used for acute pain? Yes No
 Is the requested medication being used for postoperative pain? Yes No If yes, please answer the following:
 • Has the patient already received chronic opioid therapy prior to surgery or is the postoperative pain expected to be moderate to severe and persist for an extended period of time? Yes No
 Prior to the start of therapy with the requested long-acting opioid, has the patient failed an adequate trial of a short-acting opioid? Yes No
 If yes, please document the name of the medication(s), date, and duration of trial:
 Medication: _____ Date of trial: _____ Duration of trial: _____

For diagnosis of moderate to severe neuropathic pain or fibromyalgia, please answer the following:

Does the patient have a contraindication to or has not exhibited an adequate response to treatment with gabapentin titrated to a therapeutic dose? Yes No If yes, please document dose, date, and duration of trial
 Dose: _____ Date of trial: _____ Duration of trial: _____
 Does the patient have a contraindication to or has not exhibited an adequate response to treatment with a tricyclic antidepressant titrated to the maximum tolerated dose? Yes No If yes, please document drug, dose, date, and duration of trial:
 Medication: _____ Dose: _____ Date of trial: _____ Duration of trial: _____

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Select the medications the patient has a history of failure, contraindication, or intolerance to (Document date and duration of trials):

- | | | |
|--|-------------|--------------------------|
| <input type="checkbox"/> Fentanyl transdermal patch (generic Duragesic) | Date: _____ | Duration of trial: _____ |
| <input type="checkbox"/> Morphine sulfate controlled-release tablet
(generic MS Contin) | Date: _____ | Duration of trial: _____ |
| <input type="checkbox"/> Nucynta ER | Date: _____ | Duration of trial: _____ |
| <input type="checkbox"/> Xtampza ER | Date: _____ | Duration of trial: _____ |

Reauthorization [Non-cancer and non-end of life pain only]:

If this is a reauthorization request, please answer all of the following questions:

1. What are the treatment goals for this patient? (Document treatment goals) _____
2. What alternative nonopioid analgesic and/or nonpharmacologic interventions are currently being used with this requested medication? (Document other treatment interventions) _____
3. Has the patient demonstrated meaningful improvement in pain scale score? (Document score) Yes No _____
4. What is the patient's most recent score on a substance abuse/opioid dependence risk assessment tool? (Document score) _____
5. What is the rationale for not tapering and discontinuing the requested medication? (Document rationale) _____
6. What comorbid mental health conditions has the patient been screened for? (Document mental health conditions for which the patient has been screened) _____
7. Has the state's prescription drug monitoring program (PDMP) been reviewed for this patient? Yes No None in state
What other controlled substances is the patient currently receiving? _____
8. Has the patient been assessed for risk of respiratory depression from medical comorbidities or the concurrent use of benzodiazepines or other drugs causing drug-drug interactions and the prescriber acknowledges that they have completed an assessment of increased risk for respiratory depression? Yes No _____
9. What is the patient's total daily dose? _____

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Quantity limit requests:

What is the quantity requested per DAY? _____

For diagnosis of cancer related pain or who are end of life (life expectancy < 2 years), please answer the following:

Can the requested dose be achieved by moving to a higher strength dosage form? Yes No

For diagnosis of non-cancer or non-end of life related pain, please answer the following:

Does the requested dose exceed 90 morphine equivalent doses (MED) daily? Yes No

Example of 90 MED equivalent: Exalgo (hydromorphone ER) = 24mg/day

Can the requested dose be achieved by moving to a higher strength dosage form? Yes No

Was the requested 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 along with this fax form.**

Prescriber attestation:

Does the prescriber attest that the information provided is true and accurate to the best of their knowledge and understand that ProAct may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided? Yes No

Prescriber's signature: _____ Date: _____

Please note: All information must be completed and chart documentation (i.e., chart notes) [where applicable] must be submitted to ProAct.

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.



1230 US Highway 11

Gouverneur, NY 13642

Phone: 1-877-635-9545

Prior Authorization Fax: 1-844-712-8129

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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:

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