

## Opana ER® [oxymorphone 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 <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information <small>(required)</small>
<p><b>For states, such as AR, that have a terminal illness mandate, and for patients who have a terminal illness, please answer the following:</b></p> <p>Will the requested medication be used for the treatment of a terminal condition or associated symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "YES", please indicate the patient's estimated life expectancy: <input type="checkbox"/> Less than 6 months <input type="checkbox"/> Less than _____ months (please specify)</p>
<p><b>Please answer the following:</b></p> <p>Is the patient <b>currently</b> established on the requested long-acting opioid? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient new to ProAct Insurance (as evidenced by coverage effective date of less than or equal to 120 days)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the prescriber aware that Opana ER is being withdrawn from the market due to concerns of significant abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Select all the applicable diagnoses below :</b></p> <p><input type="checkbox"/> Cancer or end of life related pain</p> <p><input type="checkbox"/> Moderate to severe chronic pain that is non-neuropathic</p> <p><input type="checkbox"/> Moderate to severe neuropathic pain or fibromyalgia (examples of neuropathic pain include neuralgias, neuropathies)</p> <p><input type="checkbox"/> Other diagnosis: _____</p>
<p><b>For diagnosis of cancer or end of life (defined as a &lt; 2 years life expectancy) related pain, please answer the following:</b></p> <p>Does the patient have an active cancer diagnosis or life expectancy of &lt; 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will medical records documenting an active cancer diagnosis or life expectancy of &lt; 2 years be submitted to ProAct® with this fax form? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>***Please note: Medical records documenting an active cancer diagnosis or life expectancy of &lt; 2 years is required to be submitted along with this fax form. ***</i></p>
<p><b>For diagnosis of moderate to severe chronic pain that is non-neuropathic, please answer the following:</b></p> <p>Is the requested medication being used as an as-needed (PRN) analgesic? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the requested medication being used for pain that is mild or not expected to persist for an extended period of time? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the requested medication being used for acute pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the requested medication being used for postoperative pain? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes</b>, please answer the following:</p> <ul style="list-style-type: none"> <li>• 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? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul> <p>Prior to the start of therapy with the requested long-acting opioid, has the patient failed an adequate trial of a short-acting opioid? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If yes</b>, please document the name of the medication(s), date, and duration of trial:</p> <p>Medication: _____ Date of trial: _____ Duration of trial: _____</p>

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**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 or therapeutic dose?  Yes  No If **yes**, please document drug, dose, date, and duration of trial:

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Date of trial: \_\_\_\_\_ Duration of trial: \_\_\_\_\_

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: \_\_\_\_\_

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

- |   |             |                          |
|---|-------------|--------------------------|
| <input type="checkbox"/> Embeda   | Date: _____ | Duration of trial: _____ |
| <input type="checkbox"/> Fentanyl transdermal patch (generic Duragesic)                 | Date: _____ | Duration of trial: _____ |
| <input type="checkbox"/> Hydromorphone ER   | 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"/> Oxycontin  | Date: _____ | Duration of trial: _____ |
| <input type="checkbox"/> Oxymorphone ER   | Date: _____ | Duration of trial: _____ |
| <input type="checkbox"/> Xtampza ER   | Date: _____ | Duration of trial: _____ |

**Clinical information [Non-cancer and non-end of life pain only]:**

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: Oxymorphone ER (generic Opana ER) = 30m g/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<sup>®</sup> 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) [w here 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.**

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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:					
<b>Clinical Review Decision</b>					
	Approved, through				
	Denied (documentation attached, if necessary)				
<b>Tracking:</b>					
1 <sup>st</sup> Attempt		2 <sup>nd</sup> Attempt		Letter Mailed:	