Maryland Medicaid
Pharmacy Program
Fax: (866) 440-9345
Phone: (800) 932-3918

Opioid
Prior Authorization Form
Incomplete forms will not be reviewed.

Patient's Information: **Date:**________________

NAME: DOB:

Participant's Maryland Medicaid Number: SEX: ❑ M ❑ F

Prescriber's Information: **Name of Facility/Clinic:**___________________________

NAME: NPI #

Phone # Fax #

Contact Person for this Request:

NAME: Phone # Fax #

**** Prior authorization is approved for a maximum of 6 months only****

❑New Prescription ❑Refill (Patient has been taking this medication)

Please check the appropriate box for the Opioid Prior Authorization request.

❑ Quantity Limit ❑ Long-Acting Opioid ❑Non-Preferred ❑ Other________________________

Use a separate form for EACH medication request:

Medication: ____ Strength: _________ Quantity: ________

SIG: ____ Length of Treatment ________ months.

Clinical Considerations:

❑ Y ❑ N Is the Patient Pregnant?

Attestation to any of the 5 statements below, exempts the claim from the Opioid PA Process.

Y	N	
❑	❑	Patient receiving opioid due to cancer treatment. Cancer type:____________________________
❑	❑	Patient receiving opioid due to sickle cell disease.
❑	❑	Patient is in hospice care.
❑	❑	Patient is receiving palliative care (ICD-10 diagnosis code of Z51.5)
❑	❑	Patient is in a LTC (Long Term Care) facility.

Attestation required for all of the following in order to receive a PA.

Y	N	
❑	❑	Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
❑	❑	Patient has/will have random Urine Drug Screens.
❑	❑	Naloxone prescription was provided or offered to patient/patient's household.
❑	❑	Patient-Prescriber Pain Management/Opioid Treatment Agreement/Contract signed and in Medical record?

I certify that the benefits of Opioid treatment for this patient outweigh the risks of treatment.

Prescriber's Signature_________________________________ Date____________________

Fax completed form to 866-440-9345.