

NC Medicaid and NC Health Choice  
Pharmacy Prior Approval Request for  
Long-Acting Opioid Analgesic



**Beneficiary Information**

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescribing Provider NPI #: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

**Drug Information**

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
11. Length of Therapy (in days):  up to 30 Days  60 Days  90 Days  120 Days  180 Days  365 Days  Other: \_\_\_\_\_

**Clinical Information**

1. Does the patient have a diagnosis of malignant cancer or pain due to neoplasm?  **Yes**  **No** If yes, the patient is exempt from the prior authorization requirement
2. Does the beneficiary have a diagnosis of chronic pain syndrome of at least four (4) weeks duration?  **Yes**  **No**
3. **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 3a and 3b when the response to question 3 is 'No'.
  - 3a. Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits.  
Please list: \_\_\_\_\_
  - 3b. Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose.  
Please list: \_\_\_\_\_
4. Is this an initial authorization request? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.  
 **Yes**  **No**
  - 4a. If Yes, has the beneficiary tried a short-acting Opioid Analgesic in the past 45 days?  **Yes**  **No**
  - 4b. If no, explain: \_\_\_\_\_
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 beneficiary 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 beneficiary'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 patient 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 patient have a contraindication or allergy to ingredients in the preferred product?  **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.