BlueCross BlueShield of North Carolina

Immediate Release Opioid Prior Authorization - Essential

Apadaz, levorphanol tartrate, Oxaydo, Prolate, Qdolo, and RoxyBond

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]	
CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX	
PRESCRIBER ADDRESS	CITY	STATE	ZIP
PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER M F

Diagnosis Code: ____________

Please select the requested medication and answer the following questions:

☐ Apadaz
☐ levorphanol tartrate
☐ Oxaydo
☐ RoxyBond tablets
☐ oxycodone / acetaminophen tablets (authorized generic Prolate tablets)
☐ Prolate tablets
☐ Prolate solution 10-300mg/5mL
☐ oxycodone HCL abuse-deterrent tablet (authorized generic RoxyBond)
☐ Qdolo solution
☐ tramadol oral solution (authorized generic Qdolo solution)

1. Please provide indication for the requested medication: ______________________________________
2. Is the requested medication and/or dose considered medical necessary and appropriate for treating the condition?..☐ Yes ☐ No
3. Is the requested medication treating a chronic, disabling, or life-threatening disease?....................☐ Yes ☐ No
4. Is the request for **Apadaz**?..☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Does the patient have a contraindication or intolerance to hydrocodone?......................☐ Yes ☐ No
      If YES, please provide medical record documentation.
   b. Does the patient have a contraindication or intolerance to codeine?.............................☐ Yes ☐ No
      If YES, please provide medical record documentation.
   c. Has the patient filled a prescription for an opioid in the past 180 days?........................☐ Yes ☐ No
      i. **If NO to 1c,** is the prescription for more than a 7 day supply?...........................☐ Yes ☐ No
      ii. **If YES to 1c,** is the prescription for more than a 14 day supply?........................☐ Yes ☐ No
5. Is the request for **levorphanol tartrate**?..☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Please select all medications the patient has tried and failed (**medical records required**):
      ☐ methadone ☐ morphine ☐ tapentadol (Nucynta) ☐ N/A
   b. Please select all medications the patient has an FDA labeled contraindication to (**medical records required**):
      ☐ methadone ☐ morphine ☐ tapentadol (Nucynta) ☐ N/A

****NOTE: continued on page 2; please complete and sign **page 3** for prior authorization request****

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(continued)

6. Is the request for **Oxaydo**, **RoxyBond, or oxycodone HCl abuse-deterrent** (authorized generic RoxyBond)?....☐ Yes ☐ No

   If YES, please answer the following questions:
   a. Does the patient have a history of substance abuse?....☐ Yes ☐ No
   b. Is it clinically appropriate for the patient to receive an opiate?....☐ Yes ☐ No

7. Is the request for **Prolate tablets** or **oxycodone/acetaminophen tablets** (authorized generic Prolate)?....☐ Yes ☐ No

   If YES, please answer the following questions:
   a. Is the patient 18 years of age and older?....☐ Yes ☐ No
   b. Please select all medications the patient has tried and failed (**medical records required**):
      ☐ generic oxycodone/acetaminophen tablets ☐ Endocet tablets ☐ Percocet tablets ☐ N/A
   c. Please select all medications the patient has an FDA labeled contraindication to (**medical records required):**
      ☐ generic oxycodone/acetaminophen tablets ☐ Endocet tablets ☐ Percocet tablets ☐ N/A

8. Is the request for **Prolate solution**?....☐ Yes ☐ No

   If YES, please answer the following questions:
   a. Is the patient 18 years of age and older?....☐ Yes ☐ No
   b. Please select all medications the patient has tried and failed (**medical records required**):
      ☐ generic oxycodone/acetaminophen tablets ☐ Endocet tablets ☐ Percocet tablets ☐ N/A
   c. Please select all medications the patient has an FDA labeled contraindication to (**medical records required**):
      ☐ generic oxycodone/acetaminophen tablets ☐ Endocet tablets ☐ Percocet tablets ☐ N/A
   d. Is the patient able to take solid dosage forms?....☐ Yes ☐ No
   e. Is the patient taking any other medication in a solid dosage form?....☐ Yes ☐ No
   f. Is the patient using an enteral feeding tube?....☐ Yes ☐ No
      i. **IF YES,** can the tablet/capsule formulation of this medication be crushed for administration (via nationally recognized organization, such as the Institute for Safe Medication Practices)?....☐ Yes ☐ No

9. Is the request for **Qdolo solution** or **tramadol solution (authorized generic Qdolo)**?....☐ Yes ☐ No

   If YES, please answer the following questions:
   a. Is the patient 12 years of age and older?....☐ Yes ☐ No
   b. Has the patient tried and failed tramadol tablets/capsules?....☐ Yes ☐ No
      If YES, please provide medical record documentation.
   c. Does the patient have a contraindication or intolerance to tramadol tablets/capsules?..☐ Yes ☐ No
      If YES, please provide medical record documentation.
   d. Is the patient able to take solid dosage forms?....☐ Yes ☐ No
   e. Is the patient taking any other medication in a solid dosage form?....☐ Yes ☐ No
   f. Is the patient using an enteral feeding tube?....☐ Yes ☐ No
      i. **IF YES,** can the tablet/capsule formulation of this medication be crushed for administration (via nationally recognized organization, such as the Institute for Safe Medication Practices)?....☐ Yes ☐ No

****NOTE: continued on page 3; please complete and sign **page 3** for prior authorization request****

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(continued)

10. Please provide previously tried and failed medications for this diagnosis (*omission of information indicates N/A or none*):

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11. Please list any medications the member has a contraindication or is intolerant to for this diagnosis (*omission of information indicates N/A or none*):

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12. Please provide a clinical rationale for the requested medication and address alternatives that have not been tried, but may be clinically inappropriate; may include medical record documentation, laboratory results, and/or other supporting medical documentation (*omission of information indicates N/A or none*):

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****PLEASE NOTE: If prescribing more than the program quantity limit (listed on page 5) please complete and sign* ***page 4*****

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_________________________________ **Date**:__________

For Blue Cross NC members, fax form to 1-800-795-9403

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COMPLETE PAGE 4 ONLY IF REQUESTING A QUANTITY LIMIT EXCEPTION FOR IMMEDIATE RELEASE OPIOIDS:

Apadaz, levorphanol tartrate, Oxaydo, Prolate, Qdolo, RoxyBond, or oxycodone HCl abuse-deterrent (authorized generic RoxyBond)

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]	
CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX	
PRESCRIBER ADDRESS	CITY	STATE	ZIP
PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER M F

FOR COVERAGE OVER THE QUANTITY LIMITS (PROGRAM MAXIMUM PER DAY OR MAXIMUM PROGRAM LIMITS) LISTED ON PAGE 5, PLEASE ANSWER THE FOLLOWING: ***Please note:*** *This medication requires a* ***prior authorization*** *before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (pages 1-3). Otherwise, this request will deny.* ***NOTE: Quantity limits apply to both brand and generic formulations***

Diagnosis Code:_____________

Medication Name and Strength: ____________________________________

Requested Quantity: ____

****Please enter quantity as a numeric value with one decimal place (ex. 1.0, 1.5)****

Per: ☐ day ☐ 30 days

****Please also select one box for per "day" or per "30 days" ****

In the space provided, please document support for the requested Quantity Limit Exception (this may include documented clinical rationale and/or medical records). **Rationale must be provided.**

____

____

Please certify the following by signing and dating below:
I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_________________________________ **Date**:__________

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Quantity Limits: Immediate release Opioids

Please note: Quantity Limits apply to both brand and generic formulations

Medication	Quantity per Day (unless specified)
Apadaz (benzydrocodone and Acetaminophen) 4.08-325 mg	12 tablets; 168 tablets (14 days) per 30 days
Apadaz (benzydrocodone and Acetaminophen) 6.12-325 mg	12 tablets; 168 tablets (14 days) per 30 days
Apadaz (benzydrocodone and Acetaminophen) 8.16-325 mg	12 tablets; 168 tablets (14 days) per 30 days
Levorphanol 2mg tablet	6 tablets
Levorphanol 3mg tablet	4 tablets
Oxaydo (oxycodone HCl abuse deterrent) 5mg tablets	12 tablets
Oxaydo (oxycodone HCl abuse deterrent) 7.5mg tablets	6 tablets
Prolate (oxycodone/acetaminophen) 10-300 mg/5 mL solution	30 milliliters
Prolate (oxycodone/acetaminophen) 5-300mg tablets	12 tablets
Prolate (oxycodone/acetaminophen) 7.5-300mg tablets	8 tablets
Prolate (oxycodone/acetaminophen) 10-300mg tablets	6 tablets
Qdolo (tramadol) 5mg/mL solution	80 milliliters
RoxyBond (oxycodone HCl abuse deterrent) 5mg tablet	12 tablets
RoxyBond (oxycodone HCl abuse deterrent) 10mg tablet	6 tablets
RoxyBond (oxycodone HCl abuse deterrent) 15mg tablet	6 tablets
RoxyBond (oxycodone HCl abuse deterrent) 30mg tablet	6 tablets

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