BlueCross BlueShield of North Carolina

Immediate Release Opioid Prior Authorization – NC Standard

Apadaz, levorphanol tartrate, Oxaydo, Prolate, and Qdolo

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
☐ oxycodone / acetaminophen tablets (authorized generic Prolate tablets)
☐ Prolate tablets
☐ Prolate solution
☐ Qdolo solution

1. 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
   b. Does the patient have a contraindication or intolerance to codeine?....................☐ Yes ☐ No
   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

2. 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:
      ☐ methadone ☐ morphine ☐ tapentadol (Nucynta) ☐ N/A
   b. Please select all medications the patient has an FDA labeled contraindication to:
      ☐ methadone ☐ morphine ☐ tapentadol (Nucynta) ☐ N/A

3. Is the request for Oxaydo?....................☐ 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

4. Is the request for Prolate tablets or oxycodone/acetaminophen tablets (authorized generic for 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:
      ☐ generic oxycodone/acetaminophen tablets ☐ Endocet tablets ☐ Percocet tablets ☐ N/A
   c. Please select all medications the patient has an FDA labeled contraindication to:
      ☐ generic oxycodone/acetaminophen tablets ☐ Endocet tablets ☐ Percocet tablets ☐ N/A

****NOTE: continued on page 2; please complete and sign* ***page 2.******

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5. 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:
      ☐ generic oxycodone/acetaminophen tablets ☐ Endocet tablets ☐ Percocet tablets ☐ N/A
   c. Please select all medications the patient has an FDA labeled contraindication to:
      ☐ 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

6. Is the request for Qdolo solution?..☐ 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
   c. Does the patient have a contraindication or intolerance to tramadol tablets/capsules?...☐ Yes ☐ No
   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

7. Please list additional medications the patient has tried and failed or has a contraindication / intolerance to (*omission of information indicates N/A or none*): ____________________________________
   ____
   ____

****PLEASE NOTE: If prescribing more than the program quantity limit (listed on page 3) please complete and sign **page 3.******

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 3 ONLY IF REQUESTING A QUANTITY LIMIT EXCEPTION FOR IMMEDIATE RELEASE OPIOIDS: Apadaz, levorphanol tartrate, Oxaydo, Prolate, and Qdolo

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 BELOW, 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 1-2). Otherwise, this request will deny.* ***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

Diagnosis Code:______________

Medication Name and Strength: ______________________________________

Requested Quantity per day: _______________

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

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.**

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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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