CareFirst Community Health Plan Maryland

PO Box 915
Owings Mills, MD 21117
Fax: (855) 762-5205
Phone: (877) 418-413

Opioid Prior Authorization Request Form

Use a separate form for each medication. Incomplete forms will not be reviewed.

PATIENT INFORMATION

Name:_____ DOB: _____

Maryland Medicaid Number:_____ Gender: ☐ Male ☐ Female

PRESCRIBER INFORMATION

Name:_____ NPI#: _____

Facility/Clinic:_____ Phone#:_____ Fax#: _____

CONTACT FOR THIS REQUEST

Name:_____ Phone#:_____ Fax#: _____

Select One: ☐New Prescription ☐Refill (i.e., patient has been taking medication)

Select All That Apply:
☐Immediate-Release Opioid ☐Extended-Release Opioid ☐Fentanyl ☐Methadone *(for pain)*
☐Other: _____

Drug Name:_____ Strength:_____ Quantity: _____

SIG:_____ Length of Treatment:_____ ☐Day(s) ☐Month(s)

Y	N	Select All That Apply
☐	☐	Patient receiving an opioid due to cancer. Cancer Type: _____
☐	☐	Patient receiving an opioid due to sickle cell disease.
☐	☐	Patient receiving palliative care.
☐	☐	Patient is in hospice care.
☐	☐	Patient is in a long-term care facility.
☐	☐	Patient is pregnant (where applicable)

Y	N	Attestations required for each of the following:
☐	☐	Prescriber has reviewed Controlled Substances Prescriptions in PDMP (CRISP).
☐	☐	Patient has/will have random Urine Drug Screens.
☐	☐	Naloxone prescription was offered or provided to patient/patient's household.
☐	☐	Patient-Prescriber Pain Management/Opioid Treatment Agreement/Contract signed and in patient's medical record?

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

Prescriber's Signature:_____ Date: _____

Fax completed form to CVS at (855) 762-5205.

Updated 6/17/17