MedStar Family Choice

DISTRICT OF COLUMBIA

All requests must be accompanied by MEDICAL RECORDS to support the request. MFC-DC MUST RENDER A DECISION WITHIN 24 HOURS. If MEDICAL RECORDS are INCOMPLETE, the request is subject to DENIAL. Phone Inquiries: 855-798-4244

OPIOID PRIOR AUTHORIZATION FORM
Please fax to 202-243-6258

Patient Name:	**Patient Phone #:**
Patient DOB:	**Medicaid ID#:**

Medication Name	**Dose (mg/mcg)**	**Directions (ex.1 po bid, 2 q6h prn, etc.)**	**Quantity to Dispense**	**Duration of Therapy (Days)**

Please check Yes or No box below:

Yes	**No**	
		1. Patient is receiving opioid therapy due to cancer or sickle cell disease. If yes, the patient is EXEMPT from PA requirements and you may stop here and sign form. Please return this PA form and last office note by fax to the number above. DX:_____________________
		2. Patient is in hospice and/or is receiving palliative care. If yes, the patient is EXEMPT from PA requirements and you may stop here and sign form. Please return this PA form and last office note by fax to the number above. DX:_____________________________________
		3. If answers to questions 1 and 2 are “no”, please specify diagnosis and return this PA form and last office note by fax to the number above. DX:_____________________________
		4. Naloxone has been offered and/or prescribed for the patient.
		5. The prescriber has checked the District of Columbia Prescription Drug Monitoring website and reviewed the patient’s prescription history.
		6. The prescriber has discussed and evaluated the risks versus benefits of opioid therapy with the patient.
		7. The prescriber has a continuous treatment relationship with the patient. If yes, continue to the question 8 below. If no (there is not a continuous treatment relationship between the prescriber and the patient as would be the case in ED visits, Inpatient hospitalizations, some surgical services), please stop here and sign form. Please return this PA form by fax to the number above.
		8. The prescriber will perform random urine drug screening during the course of opioid therapy for this patient.
		9. The prescriber and patient have signed an Opioid Treatment Agreement and it is part of the patient’s medical record.

By signing below, I certify that the information provided is accurate.

Prescriber’s Name:______________________________Contact Person for Request:________________________

Telephone#: (_____) –____________-________________ Fax#: (______) -____________- ________________

Prescriber Address: ____

Prescriber Signature:____Date:________________________