MedStar Family Choice

DISTRICT OF COLUMBIA

MedStar Family Choice-District of Columbia
Return by fax to: 202-243-6258

OPIOID PRIOR AUTHORIZATION FORM

Patient Name: _____

Patient DOB: _____

Patient Phone #: (_____) – _____- _____

Medication Prescribed: _____ _____ sig:_____ _____ _____
(Medication Name) (dose in mg.mcg) (ex: 1 po bid, 2 po tid, etc) (number to dispense) (duration of therapy)

Medication Prescribed: _____ _____ sig:_____ _____ _____
(Medication Name) (dose in mg.mcg) (ex: 1 po bid, 2 po tid, etc) (number to dispense) (duration of therapy)

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. Naloxone has been offered and/or prescribed for the patient.
☐	☐	4. The prescriber has checked the District of Columbia Prescription Drug Monitoring website and reviewed the patient's prescription history.
☐	☐	5. The prescriber has discussed and evaluated the risks versus benefits of opioid therapy with the patient.
☐	☐	6. The prescriber has a continuous treatment relationship with the patient. If yes, continue to the question 7 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.
☐	☐	7. The prescriber will perform random urine drug screening during the course of opioid therapy for this patient.
☐	☐	8. 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:_____