BlueCross BlueShield of North Carolina

Immediate Release Opioid Prior Authorization
Enhanced & Net Results Formularies

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

Select the requested medication & answer the following questions: **Diagnosis Code: _____**

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

1. Is the request for Xyvona or 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

2. Is the request for 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

3. 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 (**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

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

Immediate Release Opioid Prior Authorization: Enhanced & Net Results (*continued*)

4. Is the request for Prolate 10-300mg/5mL solution or oxycodone/acetaminophen 10-300 mg/5 mL solution (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
   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
5. 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
6. 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 4) 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

BlueCross BlueShield of North Carolina

COMPLETE PAGE 3 ONLY IF REQUESTING A QUANTITY LIMIT EXCEPTION FOR IMMEDIATE RELEASE OPIOIDS:

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

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 4, 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***

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**:_____

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

Quantity Limits: Immediate release Opioids

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

Medication	Quantity per Day (unless specified)
Xyvona (levorphanol) 2mg tablet	6 tablets
Xyvona (levorphanol) 3mg tablet	4 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