# Immediate Release Opioid Prior Authorization - Essential

## levorphanol tartrate, Prolate, Qdolo, RoxyBond, and Xyvona

**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:**

☐ 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. Please provide indication for the requested medication: _____
2. Is the requested medication and/or dose considered medical necessary and appropriate for treating the condition?.....☐ Yes ☐ No
3. Is the requested medication treating a chronic, disabling, or life-threatening disease?.....☐ Yes ☐ No
4. 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
5. 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

****continued on page 2; please complete and sign **page 3** for prior authorization request****

# Immediate Release Opioid Prior Authorization – Essential *(continued)*

6. Is the request for **Prolate tablets** or **oxycodone/acetaminophen tablets** (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

7. Is the request for **Prolate 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

8. 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

****continued on page 3; please complete and sign **page 3** for prior authorization request****

# Immediate Release Opioid Prior Authorization - Essential

***(continued)***

9. Please provide previously tried and failed medications for this diagnosis (*omission of information indicates N/A or none*):

   _____

   _____

10. Please list any medications the member has a contraindication or is intolerant to for this diagnosis (*omission of information indicates N/A or none*):

    _____

    _____

11. Please provide a clinical rationale for the requested medication and address alternatives that have not been tried, but may be clinically inappropriate; may include medical record documentation, laboratory results, and/or other supporting medical documentation (*omission of information indicates N/A or none*):

    _____

    _____

****PLEASE NOTE: If prescribing more than the program quantity limit (listed on page 5) please complete and sign **page 4******

**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 4 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 5, 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 1-3). 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 |