Prior Authorization Form

Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Oramorph Extended Release PL (Medicare Prior Auth)
This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at **1-888-836-0730**.
Please contact CVS|Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Oramorph Extended Release PL (Medicare Prior Auth).

Drug Name (select from list of drugs shown)
Oramorph SR 100mg (morphine sulfate ER) Tab

Patient Information
Patient Name: ____________________
Patient ID: ____________________
Patient Group No.: ____________________
Patient DOB: ____________________

Prescribing Physician
Physician Name: ____________________
Physician Phone: ____________________
Physician Fax: ____________________
Physician Address: ____________________
City, State, Zip: ____________________

Diagnosis: ____________________ ICD Code: ____________________

Please circle the appropriate answer for each applicable question.

1. Does the patient have a diagnosis of moderate to severe pain? Y N
2. Is the patient being prescribed extended release morphine for continuous, around-the-clock pain relief? Y N
3. Has the patient been assessed for clinical risks of opioid abuse and/or addiction by one of the following tools, or another assessment tool for opioid abuse: CAGE questionnaire, Cyr-Wartman Screen, Skinner Trauma Screen, Screener and Opioid Assessment for Patients with Pain (SOAPP)? Y N
4. Is the drug being requested MS Contin, Oramorph SR, or Extended Release Morphine? Y N
   [If the answer to this question is no, then skip to question 6.]
5. Is the drug being dosed more often than every 8 hours? Y N
   [No further questions are required.]
6. Is the request for Kadian? Y N
   [If the answer to this question is no, then skip to question 8.]
7. Is the drug being dosed more often than every 12 hours? Y N
   [No further questions are required.]
8. Is the request for Avinza? Y N

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[If the answer to this question is no, then no further questions required.]

9. Is the drug being dosed more often than every 24 hours? Y N
10. Does the total daily dose of Avinza exceed 1600 mg? Y N

Comments: ______________________________

I affirm that the information given on this form is true and accurate as of this date.

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Prescriber (Or Authorized) Signature and Date