WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES
West Virginia Medicaid

Chronic Opioid Prior Authorization Form

The info requested in this form, although extensive, is based on best practice standards and the CDC Chronic Pain Opioid Guidelines. It is intended to facilitate the safe and effective treatment, improve outcomes, and reduce adverse events including opioid use disorder and/or overdose.

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Phone: 1-800-847-3859
Fax: 1-800-531-7787

Date	Diagnosis:

Requested Medication(s)

Medication	Strength	Direction for use	Quantity requested per 30 days
			□ 30 □ 60 □ 90 □ 120 □ Other:_____
			□ 30 □ 60 □ 90 □ 120 □ Other:_____
			□ 30 □ 60 □ 90 □ 120 □ Other:_____

Patient Information

Patient's Last Name:	First:	Middle:	Member ID Number:	Date of Birth:
Street Address:		City		
State:	Zip Code:	Sex ❑ M ❑ F	Race/Ethnicity:	

Prescriber Information

Prescriber's Last Name:	First:	Middle	Prescriber's NPI #:	Prescriber's DEA #:
Prescriber's Specialty:	I certify that I have not charged cash for this office visit or for the treatment of this patient's pain management ❑ Yes ❑ No			
Street Address:		City:		
State:	Zip:	Phone Number:	Fax Number:	

Pharmacy Information

Name:	Phone Number:

Medical information

Please attach or list patient's current complete treatment list with the medical condition being treated included for each.
(Non-Pharmacological, Prescriptions, OTCs, Herbals, Supplements, & Illicit Substances)

Current treatments	Previously failed pain treatments of any/all types

Is the patient pregnant?	❑ Yes ❑ No
Is the patient allergic to any opioid medications? (If yes, please list and describe reactions in 2 to 3 words)	❑ Yes ❑ No
Does the patient have normal renal or hepatic function? (If No, please provide GFR, CrCl, and/or Hepatic Panel respectively)	❑ Yes ❑ No

IF YOU DO NOT RECEIVE BOTH PAGES PLEASE CALL 1-800-847-3859

Physical exam findings relevant to pain diagnosis (Please briefly describe after Height, Weight, & Vital Signs)

Height:	Weight:	Blood Pressure:	Heart Rate:	Respiratory Rate:

Laboratory findings relevant to pain diagnosis (Please attach and/or briefly describe)

Radiological findings (MRI, X-Ray, or Ultrasound) relevant to the pain diagnosis (Please briefly describe)

Has the patient experienced a decrease in his/her daily function (i.e. ability to climb stairs, complete house work, perform tasks, etc.) beyond a subjective increase in daily pain? ❑ Yes ❑ No

Has the patient been screened for risk of substance-use disorder? (Please indicate risk screening tool, result, and attach) ❑ Yes ❑ No

❑ Opioid Risk Tool (ORT)
❑ Drug Abuse Screening Test (DAST)
❑ Diagnosis, Intractability, Risk, & Efficacy Score (DIRE)
❑ Current Opioid Misuse Measure (COMM)
❑ Prescription Drug Use Questionnaire (PDUQ)
❑ Pain Medication Questionnaire (PMQ)

What was the patient's risk of substance abuse based on the above screening tool? ❑Low ❑ Moderate ❑ High

Does the patient currently have an up-to-date & signed Patient & Provider Agreement (Please Attach) including:

- Therapeutic goals of reducing pain and improving functional outcomes
- Treatment time frame with a planned end point as appropriate
- Review of the associated risks of opioid therapy

❑ Yes ❑ No

Has the patient been educated on the proper storage/disposal of controlled substances? ❑ Yes ❑ No

Patient's opioid daily dose is >50MME/day. The CDC Opioid guidelines recommend education & utilization of naloxone.

Has the patient been educated on being a candidate for carrying naloxone? ❑ Yes ❑ No

Has the patient been prescribed naloxone? ❑ Yes ❑ No

WV Code §60A-9-5a requires initial and at least annual review of the Prescription Drug Monitoring Program (PDMP). Has the PDMP been reviewed immediately prior to the prescribing of the requested opioid medication? (If any unexpected results existed, please attach a copy to this request or briefly explain) ❑ Yes ❑ No

This confirmatory information will be shared with the WV PDMP administration.

Has a Urine Drug Screening been completed prior to the prescribing of the requested opioid medication? ❑ Yes ❑ No

Were the results consistent with current treatment and devoid of illicit substance? (Please submit results with each request.) ❑ Yes ❑ No

Practitioner Signature:_____**Date**_____

(If a signature stamp is used, then the prescribing practitioner must initial the signature, signatures by agents of the practitioner are not acceptable)