CareFirst
Community Health Plan
Maryland

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Timonium, MD 21093
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Opioid Prior Authorization Request Form

Use a separate form for each medication. Incomplete forms will not be reviewed.

PATIENT INFORMATION

Name:______________________________ DOB: ______________

Maryland Medicaid Number:__________________ Gender: ☐ Male ☐ Female

PRESCRIBER INFORMATION

Name:______________________________ NPI#: ______________

Facility/Clinic:________________ Phone#:__________ Fax#: __________

CONTACT FOR THIS REQUEST

Name:________________ Phone#:____________ Fax#: ____________

Select One: ☐New Prescription ☐Refill (i.e., patient has been taking medication)

Select All That Apply:
☐Immediate-Release Opioid ☐Extended-Release Opioid ☐Fentanyl ☐Methadone *(for pain)*
☐Other: ____________________

Drug Name:________________ Strength:____________ Quantity: ________

SIG:____________________ Length of Treatment:______ ☐Day(s) ☐Month(s)

Y	N	Select All That Apply
☐	☐	Patient receiving an opioid due to cancer. Cancer Type: ________________
☐	☐	Patient receiving an opioid due to sickle cell disease.
☐	☐	Patient receiving palliative care.
☐	☐	Patient is in hospice care.
☐	☐	Patient is in a long-term care facility.
☐	☐	Patient is pregnant (where applicable)

Y	N	Attestations required for each of the following:
☐	☐	Prescriber has reviewed Controlled Substances Prescriptions in PDMP (CRISP).
☐	☐	Patient has/will have random Urine Drug Screens.
☐	☐	Naloxone prescription was offered or provided to patient/patient's household.
☐	☐	Patient-Prescriber Pain Management/Opioid Treatment Agreement/Contract signed and in patient's medical record?

I certify the benefits of Opioid treatment for this patient outweigh the risks of treatment.

Prescriber's Signature:____________________ Date: ______________

Fax completed form to CVS at (855) 762-5205.

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