Prescription Medication Prior Authorization Request Form

☐ Standard PA Request ☐ Urgent/Expedited PA Request

Please fill out all sections and attach any important documentation such as chart notes or lab results to support the PA request.
Once completed, submit to WithMe Health via fax at **1-866-678-8301**

Patient Information

Patient Name (Last, First, MI):		
Member ID Number:	Date of Birth:	Patient Phone Number:
Patient Address:		
Patient's Authorized Representative (If applicable):		Authorized Rep Phone Number:

Provider Information

Requesting Provider's Name:		
NPI:	Specialty:	
Office Address:		
Office Phone:	Office Fax:	
Office Contact Name:	Phone:	Fax:
Dispensing Pharmacy Name/Place of Service:	Phone:	Fax:

Requested Medication Information

Medication Name and Strength:	
Dose and Frequency (Sig):	
Qty Per 30 Days:	Expected Duration of Therapy:
ICD-10(s):	Diagnosis:

Please check one of the boxes below. If established, please include therapy start date:

☐ New Therapy ☐ Samples ☐ Clinical Trial ☐ Established Date Therapy Started: _____

Previous Therapies Used for Diagnosis (Rx and OTC products)

Medication Name, Strength, Dose, Frequency	Dates Used	Outcome of Therapy (e.g., Ineffective, Not Tolerated)

Medical Rationale for Use of Requested Medication (**Please attach chart notes, lab work etc. when submitting this request. If applicable, please include why formulary therapies may be contraindicated for this patient.** Please also include which therapies will be used along with the requested medication. If patient is established on the requested medication, please include recent documentation of how the patient has responded to therapy.):

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Disease State Specific Questions

Please provide the following information:

1. Please indicate which of the following apply to the patient:
   - ☐ patient has intractable pain due to an active cancer diagnosis
   - ☐ patient has intractable pain due to a sickle cell anemia diagnosis
   - ☐ patient has intractable pain due to palliative or hospice care
   - ☐ patient has intractable pain and is a resident of a long-term care (LTC) facility
   - ☐ patient has chronic non-cancer pain over the past 90 days requiring 24-hour therapy
2. If the patient has chronic non-cancer pain over the past 90 days requiring 24-hour therapy, please provide the following:

   ☐ Documentation and complete medical history showing previous and ongoing therapy, including pharmacologic and non-pharmacologic treatments.

   ☐ Documentation that the following non-opioid medications have been ineffective, contraindicated or not tolerated (refer to applicable formulary for preferred alternatives):
      - ☐ Acetaminophen (Tylenol) up to 3g/day
      - ☐ Non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen, etodolac, diclofenac, or meloxicam
      - ☐ Antidepressants/anticonvulsants for nerve (neuropathic) pain such as duloxetine, gabapentin, amitriptyline.

   ☐ Documentation that at least one non-pharmacological therapy such as physical therapy, exercise, weight loss or Cognitive Behavioral Therapy (CBT) has been ineffective, contraindicated or not tolerated.

   ☐ Documentation that the available immediate-release/short-acting opioids (Appendix 1) have been ineffective, not tolerated, or contraindicated (refer to applicable formulary for preferred alternatives).

   ☐ Documentation of a treatment plan for the patient with established therapy and functional goals.

   ☐ Documentation of an established pain agreement between the prescriber and patient that includes, but is not limited to, random urine drug screening (UDS), an explanation of the interpretation and potential consequences of the UDS results.

   ☐ Documentation that the prescriber and patient have discussed the risks and possible benefits of opioid therapy prior to and during the course of therapy.

3. If the patient has chronic non-cancer pain over the past 90 days requiring 24-hour therapy, is the prescribed long-acting or extended-release opioid being used as an acute or "as-needed" treatment for pain? ☐ Yes ☐ No

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by WithMe Health, the health plan sponsor, or, if applicable, a state or federal regulatory agency.

_____ _____

Provider Signature Date

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