MedStar Family Choice

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Important Opioid Prior Authorization Reminder

MedStar Family Choice (MFC) appreciates the practitioners in our network who are caring for our members. When prescribing opioid medications, the MFC opioid prior authorization form **must** be completed. A completed form includes current clinical note(s) within three months or less to support the medical necessity of the opioid. The form is attached and also can be found on our website at https://www.medstarfamilychoice.com/maryland-providers, then click on the Pharmacy and Formulary tile in the center of the page.

Thank you,

MedStar Family Choice
Utilization Management Department
410-933-2200, option 2, then option 1

MedStar Family Choice

All requests must be accompanied by MEDICAL RECORDS to support the request. MFC-Maryland MUST RENDER A DECISION WITHIN 24 HOURS. If MEDICAL RECORDS are INCOMPLETE, the request is subject to DENIAL. Return by fax to MedStar Family Choice-Maryland at: 410-933-2274

ANALGESIC OPIOID PRIOR AUTHORIZATION FORM

Patient's Information:

NAME: DOB:

SEX: ❑ M ■ **F** **MFC ID or MA number:**

Prescriber's Information: **Name of Facility/Clinic:**

NAME: NPI #

Phone # Fax #

Contact Person for this Request:

NAME: Phone: Fax:

**** Prior authorization is approved for 6 months only****
□ New Prescription □ Refill (Patient has been taking this medication)

**** Diagnosis with ICD10****_____

Please check the appropriate box for the Opioid Prior Authorization request.
□ Quantity Limit □ High Dose □ Long-Acting Opioid □ Non-Preferred
□ Methadone for Pain □ Fentanyl □ Other_____

Use a separate form for EACH medication request:
Medication:_____Strength: _____Quantity: _____

SIG: _____Length of Treatment_____months

Clinical Consideration: If "Y" please submit supporting clinical documentation to support use.

Y	N	
❑	❑	Patient receiving opioid due to cancer treatment. Cancer type:_____
❑	❑	Patient receiving opioid due to sickle cell disease.
❑	❑	The patient is in hospice or is receiving palliative care.
❑	❑	Patient is Pregnant (where applicable)
❑	❑	Is this patient being discharged from the hospital or ED?
❑	❑	Is this being prescribed by a Dentist?
■	■	Is the member being discharged from a post-op procedure? Type of procedure performed_____

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

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

Prescriber's Signature_____ **Date**_____

Fax completed form to 1-888-243-1790 or 410-933-2274

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