



PREAUTHORIZATION FORM
Opioid Analgesics Quantity Request

Therapeutic use: Due to safety concerns with high dose narcotic medications, quantity limits are implemented to assure the patient's pain is being managed safely and adequately. If the patient's dose is increased in excess of the approved quantity, a new request will need to be submitted.

Quantity Limit: NA

Authorization Period: 12 months

Patient's name _____

Patient's ID# DOB / /

ICD-9

Physician's name _____

Physician's Ph# () - Fax# -

Physician's signature _____ Date signed / /

Supervising Physician's name _____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" and respond to the following requests:

1.	Medication Requested and Strength:	<input type="text"/>
	Directions for Use	<input type="text"/>
	Quantity Requested (per day, month)	<input type="text"/>
	Justification for Requested Dosage	<input type="text"/>

2.	Please list concomitant and past pain medications			
	Medication	Strength	Directions	Duration of Therapy
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3.	Please list all other applicable non-pharmacologic alternatives utilized for pain management.	
	<input type="text"/>	
	<input type="text"/>	

4. Please include recent patient progress notes, or consultation notes from a specialist if applicable.

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

