03/24/2011

Prior Authorization Criteria Form

BLUE CHIP FOR MEDICARE

Kadian Extended Release PL (Medicare Prior Auth)

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS|Caremark at **1-888-836-0730**.

Please contact CVS|Caremark at **1-877-203-0814** with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Kadian Extended Release PL (Medicare Prior Auth).

Drug Name (select from list of drugs shown)

Kadian ER (morphine sulfate)

Patient Information

Patient Name: ______________________________

Patient ID: ______________________________

Patient Group No.: ______________________________

Patient DOB: ______________________________

Prescribing Physician

Physician Name: ______________________________

Physician Phone: ______________________________

Physician Fax: ______________________________

Physician Address: ______________________________

City, State, Zip: ______________________________

Diagnosis: ______________________________ **ICD Code:** ______________________________

Please circle the appropriate answer for each applicable question.

1. Does the participant have a diagnosis of moderate to severe pain? Y N
2. Is the participant being prescribed extended release morphine for continuous, around-the-clock pain relief? Y N
3. Has the participant been assessed for clinical risks of opioid/substance abuse/or addiction by one of the following tools, or another assessment tool for opioid abuse: CAGE questionnaire, Cyr-Wartman Screen, Skinner Trauma Screen, Screener and Opioid Assessment for Patients with Pain (SOAPP)? Y N
4. Is the drug being requested MS Contin, Oramorph SR, or Extended Release Morphine? Y N

   [If the answer to this question is no, then skip to question 6.]
5. Is the drug being dosed more often than every 8 hours? Y N

   [No further questions are required.]
6. Is the request for Kadian? Y N

   [If the answer to this question is no, then skip to question 8.]
7. Is the drug being dosed more often than every 12 hours? Y N

   [No further questions are required.]

8. Is the request for Avinza? Y N

[If the answer to this question is no, then skip to question 11.]

9. Is the drug being dosed more often than every 24 hours? Y N

10. Does the total daily dose of Avinza exceed 1600 mg? Y N

11. Is the request for Embeda? Y N

[If the answer to this question is no, then no further questions are required.]

12. Is the drug being dosed more often than every 12 hours? Y N

Comments: ____________________

I affirm that the information given on this form is true and accurate as of this date.

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Prescriber (Or Authorized) Signature and Date