Prior Authorization Form

Duragesic Post Limit

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 **1-866-217-5644**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Duragesic Post Limit.

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for pain associated with cancer, a terminal condition, or pain being managed through hospice or palliative care? Y N

[If yes, then no further questions.]

2. Is the requested drug being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid? Y N

[Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.]

3. Can the patient safely take the requested dose based on their history of opioid use? Y N

4.	Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder?	Y N
5.	Will the patient's pain be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety?	Y N
6.	Does the patient require use of MORE than 20 patches/month of Duragesic?	Y N

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 the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date