Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Zohydro ER® (hydrocodone bitartrate)

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New Request ☐ Continuation Request

Drug product:
- ☐ Zohydro ER 10 mg capsule
- ☐ Zohydro ER 15 mg capsule
- ☐ Zohydro ER 20 mg capsule
- ☐ Zohydro ER 30 mg capsule
- ☐ Zohydro ER 40 mg capsule
- ☐ Zohydro ER 50 mg capsule

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Precertification Requirements

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Must be age 18 or older
2. Patient must have a documented diagnosis of chronic pain requiring daily, around the clock, long-term treatment
   - Zohydro ER is not covered for:
     - As needed use,
     - Acute pain, or
     - Post-operative pain.
3. Must first try one of the following drugs: morphine sulfate extended-release, fentanyl patch, methadone
4. Must first try one non-opioid or immediate-release opioid drug (unless contraindicated)

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 05/2016
Last reviewed 05/2019

- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Chronic pain requiring daily, around the clock, long-term treatment
☐ *Other – the patient's condition is:* _____

B. Which of the following drugs has the patient tried?

☐ Extended-release morphine sulfate
☐ Fentanyl patch (generic Duragesic)
☐ Methadone

C. What other drugs has the patient first tried for his or her pain?

☐ Yes (list below) ☐ No

Drug	Dose	Dates	Outcome

Additional information

Conversion factors to Zohydro ER (not equianalgesic doses)

Drug name	Conversion factor
Hydrocodone	1
Oxycodone	1
Methadone	1
Oxymorphone	2
Hydromorphone	2.67
Morphine	0.67
Codeine	0.1

Priority Health Medicare exception request

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Zohydro ER likely be the most effective option for this patient?

☐ No
☐ Yes, because: _____

If the patient is currently using Zohydro ER, would changing the patient's current regimen likely result in adverse effects for the patient?

☐ No
☐ Yes, because: _____

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Updated 05/2016
Last reviewed 05/2019