

PRIOR AUTHORIZATION REQUEST FORM EOC ID:

SWHP Short Acting Opioid PA Program

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:		Prescriber Name: Supervising Physician:	
Patient Name:		Supervising Physician:	
Member/Subscriber Number:		Fax:	Phone:
Date of Birth:		Office Contact:	
Group Number:		NPI:	State Lic ID:
Address:	Address:		
City, State ZIP:		City, State ZIP:	
Primary Phone:		Specialty/facility name (if	applicable):
Drug Name and Strength:			
Directions / SIG:			
Please attach any pertiner		ormation for this patient that may wing questions and sign.	support approval. Please answer the
Q1. Please specify the quar	ntity and days supply be	eing requested.	
Q2. Please indicate diagnos	sis and ICD code.		
	·	n that includes but is not limited cological agents for pain relief as	to a specific treatment objective and sappropriate?
☐ Yes		□No	
Q4. Has the patient signed	an informed consent do	cument and has an addiction ris	sk assessment been performed?
☐ Yes		□No	
Q5. Has the patient signed of other substances?	a written agreement ad	dressing issues of prescription	management, diversion, and the use
☐ Yes		□No	
Q6. Does the patient have a	a cancer diagnosis?		



PRIOR AUTHORIZATION REQUEST FORM EOC ID:

SWHP Short Acting Opioid PA Program

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

	Prescriber Name:
Patient Name:	Supervising Physician:
☐ Yes	□No
Q7. Is the patient currently enrolled in hospice?	
Yes	□No
Q8. Please indicate and/or attach supporting rationale for r	eason for request.
Q9. Additional Comments:	
Prescriber Signature	Date
□ Expedited/Urgent - By checking this box and signing abov seriously jeopardize the life or health of the enrollee or the e	e, I certify that applying the standard review timeframe may nrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document