



### Opioid Quantity Limit

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

|   |                 |
|---|-----------------|
| <b>DATE OF REQUEST:</b>   |                 |
| <b>MEMBER INFORMATION</b>   |                 |
| Last Name:  | First Name:     |
| Molina ID:  | DOB:            |
| <b>PRESCRIBER INFORMATION</b>   |                 |
| Last Name:  | First Name:     |
| NPI:  | Specialty:      |
| Phone:  | Fax (required): |
| Person to contact regarding this request:   |                 |
| <b>MEDICATION INFORMATION</b>   |                 |
| Drug Name and Strength:   |                 |
| Quantity:   | Dosing:         |
| Diagnosis:  | Duration:       |
| <b>COVERAGE CRITERIA</b>  |                 |
| Check all the applicable boxes to indicate each item as true for the recipient:<br><i>Must meet <u>all</u> of the following:</i>  |                 |
| <input type="checkbox"/> Recipient has chronic pain or requires an extended opioid therapy and is under the supervision of a licensed prescriber.<br><input type="checkbox"/> Pain cannot be controlled through the use of non-opioid therapy (APAP, NSAID's, Antidepressants, anti-seizure medications, physical therapy, etc.).<br><input type="checkbox"/> The lowest effective dose is being requested.<br><input type="checkbox"/> A pain contract is on file.   |                 |
| <b>OR</b>   |                 |
| <i>Must meet <u>one</u> of the following:</i>   |                 |
| <input type="checkbox"/> Recipient has cancer/malignancy related pain.<br><input type="checkbox"/> Recipient is post-surgery with an anticipated prolonged recovery (greater than three months).<br><input type="checkbox"/> Recipient is receiving palliative care.<br><input type="checkbox"/> Recipient is residing in a long-term care facility.<br><input type="checkbox"/> Recipient is receiving treatment for HIV/AIDS.<br><input type="checkbox"/> Prescription is written by or in consultation with a pain specialist. |                 |
| <b>PROVIDER CERTIFICATION – Prescriber's signature and date required.</b>   |                 |
| I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.  |                 |
| Prescriber's Signature: _____   | Date: _____     |

*This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.*