



Pain Management

PATIENT NAME _____
D.O.B. ___/___/___ MEMBER ID# _____ DURATION _____
DRUG REQUESTED _____
DOSAGE and Sig. (PLEASE PRINT) _____ FAX ATTENTION: _____
PHYSICIAN _____ PH# (____) _____ FAX# (____) _____
PHYSICIAN ADDRESS _____

***Please Note:** ALL are required fields above

<< Additional Drug Specific forms are available at UnisonHealthPlan.com >>

HISTORY OF PRESENT ILLNESS

Diagnosis: _____ Date of initial diagnosis? _____

Requested Drug, Dose, and Duration of Therapy: _____

(If request is being made for a diagnosis other than Cancer, please complete the following questions. If request is being made for Cancer diagnosis, please attach documentation (ie. chemotherapy records, clinical chart notes) confirming this diagnosis)

1. Does this patient have chronic severe pain (>6/10 on pain scale)? Circle one: Yes or No
2. Is the medication dosage stable or has it increased? Circle one: Stable Increased
3. Is there evidence that the patient has used narcotic medications inappropriately in the past?
Circle one: Yes or No. If yes, please explain _____

4. Is the medication being requested as a basis for pain relief with use of a maximum of one other narcotic agent for the treatment of breakthrough pain? Circle one: Yes or No
5. What other medications are being used? Circle all that apply:
Antidepressants Membrane stabilizers Other Analgesics
6. Please provide specific details of the short and long term prescription treatment plan and goals of therapy in the space provided below. Also, please provide specific details on the plans for follow up with this patient's response to therapy. Attach additional forms if necessary:

The purpose of this worksheet is to provide complete information regarding the physician's request for a non-formulary or prior authorization medication. It will be reviewed and notification of approval or denial will be given within 24 hours. Thank you.

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