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Date _____

PRIOR AUTHORIZATION QUESTIONNAIRE – Hysingla™ ER (hydrocodone bitartrate) (Page 1 of 3)

M.D. Last Name: _____ ***M.D. First Name:*** _____

Physician Phone: _____ ***Physician Fax:*** _____

Physician Address: _____ ***Physician NPI/DEA#:*** _____

Patient _____ ***ID#*** _____ ***DOB*** _____

****FAILURE TO COMPLETE THE FORM MAY RESULT IN A DELAY OR AN AUTOMATIC DENIAL****
SUBMIT ALL SUPPORTING DOCUMENTATION – CHART NOTES ARE REQUIRED

1. Diagnosis:
   - ☐ Chronic pain associated with cancer or end-of-life care **(Proceed to Question #15)**
   - ☐ Noncancer-related pain
     - a. Indicate severity: ☐ Mild ☐ Moderate ☐ Severe
     - b. Is the pain chronic? ☐ Yes ☐ No
   - ☐ Other* (please specify): _____
     ***If diagnosis of "Other" is used, please attach a clinical study with efficacy and safety data supporting this request**

2. Is the patient 18 years of age or older? ☐ Yes ☐ No

3. Has the prescriber evaluated the patient's risk for serious opioid adverse events (e.g. respiratory depression/sedation)? ☐ Yes ☐ No

4 **Medication History:**
Has the patient tried/failed/intolerant to previous therapy for pain? ☐ Yes ☐ No

   a. If Yes, specify the drug(s), dates & duration of treatment, and reason for discontinuation.

Chart Notes REQUIRED that document previous therapy and provides the rationale why that therapy did not adequately meet the patient's goals of pain management

Drug(s)	Date(s) Used	Duration of Treatment	Reason for Discontinuation

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Patient _____ ***ID#*** _____ ***DOB*** _____

b. If No, provide the Clinical Rationale for prescribing Hysingla™ ER over other therapy for pain.

_____

_____

5. **Medical History:**
Check **all** that apply – Patient's medical records include:

☐ Level of pain at baseline ☐ Functional status at baseline ☐ Goals used to determine treatment success

Continuation of therapy:
Check **all** that apply – Patient's medical records include:

☐ Level of pain during treatment ☐ Medical rationale for continuing or modifying treatment

☐ Member is progressing towards measurable treatment goals set at the beginning of treatment

☐ At least **ONE** referral to a physician has been made that specializes in the area of practice thought to be the source of the chronic pain

6. Will the patient be taking Hysingla™ ER more than every 24 hours? ☐ Yes ☐ No

7. Is the patient being prescribed Hysingla™ ER for around the clock pain relief? ☐ Yes ☐ No

8. From the options below, indicate what most accurately describes your patient:
☐ New to Hysingla™ ER and opioid tolerant ☐ New to Hysingla™ ER and opioid naïve

Continuation of therapy:
☐ No change to current dose ☐ Change in current dose. Current dose: _____

9. Dose requested: _____ mg Frequency: every _____ hours

10. Quantity requested: _____ for a 30-day supply
(Hysingla™ ER is limited to #30 tablets per 30 days)

11. Is the patient being prescribed an as-needed analgesic for breakthrough pain? ☐ Yes ☐ No

a. If Yes, specify the drug(s), strength(s), and directions of use.

_____

(Continue to page 3)

Date _____

PRIOR AUTHORIZATION QUESTIONNAIRE – Hysingla™ ER

Patient _____ ***ID#*** _____ ***DOB*** _____

12. Is the patient currently taking any benzodiazepines (e.g. alprazolam, diazepam, lorazepam)? ☐ Yes ☐ No

    a. If Yes, specify the drug(s) – Will the patient continue ≥3 months if Hysingla™ ER is approved? ☐ Yes ☐ No

    _____

    b. If No, proceed to Question #13

13. Physician's specialty: _____ **and** DEA #: _____

14. Has a random urine drug screening (UDS) been completed within the last 12 months? ☐ Yes ☐ No

    a. If Yes, provide date of screening: _____

15. **Physician Signature** or name and title of staff member providing answers _____

****Please include Chart Notes that outlines the patient's treatment plan (short and long-term goals) with this request.**

Physician's Comments:

_____

_____

_____

Submit completed form to Restat (UHA's Pharmacy Benefits Manager):

Fax completed form to:
888-853-7871

Restat
11900 W. Lake Park Dr.
Milwaukee, WI 53224

www.restat.com

Questions, please call:
877-525-5125

 Effective: 7/1/2015