Concurrent Opioid Benzodiazepine
Prior Authorization Form

Date: _____ Date Medication Required:_____

Phone: 1-866-399-0928 Fax: 1-855-678-6976

Patient Information			
Last Name:	First Name:	Middle:	DOB: ____/____/_____
Address:	City:	State:	Zip:
Daytime Phone:	Evening Phone:	Sex: ☐ Male	☐ Female

Insurance Information (Attach copies of cards)			
Primary Insurance:		Secondary Insurance:	
ID #	Group #	ID #	Group #
City:	State:	City:	State:

Physician Information			
Name:	Specialty:	NPI:	
Address:	City:	State:	Zip:
Phone #:	Secure Fax #:	Office contact:	

Physician's Signature _____ **Date:** _____ ☐ DAW

PA is required for the following:

- **Claim(s) for new opioid(s) to be used concurrently with benzodiazepines and exceeding 7 days within a 180-day period**
- **Claim(s) for new benzodiazepine(s) to be used concurrently with opioids and exceeding 7 days of therapy within a 180-day period and/or exceeding established benzodiazepine/opioid concurrent therapy quantity limits (see Sedative Hypnotics Benzodiazepine PA criteria).**

Benzodiazepine Agent(s)	Prescriber Name	Quantity	Dosage Regimen/Duration

Opioid Agent(s)	Prescriber Name	Quantity	Dosage Regimen/Duration

***NOTE: If prescribers of the opioids and benzodiazepines are not the same, please answer the following questions:**

- Are you requesting PA for: Benzodiazepine Agent(s) ☐ Opioid Agent(s) ☐ Both ☐
- Is/are the other prescriber(s) aware of the request for concurrent therapy? Yes ☐ No ☐
- Has the other prescriber been consulted about the risk associated with concurrent therapy, and do all prescribers involved believe continuing with concurrent therapy is warranted, given the risks associated with concurrent use?

  Yes ☐ No ☐

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Date: _____ Date Medication Required:_____

PA Requirements:

Member diagnosis(es) for use of benzodiazepine therapy:

Prior therapies attempted for the above diagnosis(es):

Drug Therapy	Dosage Regimen	Dates of Utilization

Do you plan to continue benzodiazepine therapy for this member? ☐ Yes ☐ No
If no, please provide withdrawal plan:

Member diagnosis(es) for use of opioid therapy:

Prior therapies attempted for the above diagnosis(es):

Drug Therapy	Dosage Regimen	Dates of Utilization	Reason for Discontinuation

Do you plan to continue opioid therapy for this member? ☐Yes ☐ No
If no, please provide withdrawal plan:

Attestation:

I, _____, hereby attest to the following:
(Prescriber Name)

- **The member's INSPECT report has been evaluated and continues to be evaluated on a regular basis (per IC 35-48-7-11.1, DO NOT attach a copy of the INSPECT report to this PA request)**
- **I have educated the member in regards to the risks of concurrent utilization of benzodiazepine and opioid therapy, and the member accepts these risks**
- **If applicable, I have consulted other prescribers involved in concurrent therapy and all prescribers involved agree to pursue concurrent opioid and benzodiazepine therapy for this member**
- **I acknowledge, as the prescriber initiating or maintaining concurrent benzodiazepine and opioid therapy, the risk of adverse event(s), including respiratory depression, coma, and death, associated with concurrent utilization**

Prescriber Signature:_____

Prescriber signature is required for consideration. Electronic or stamped signature will not be accepted