Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Levorphanol
(levorphanol tartrate)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ☐ Levorphanol ICD10:

Strength and Directions for use: Quantity per month requested: Expected Duration

Has your patient been titrated to the requested dose? ☐ Yes ☐ No
(if yes) What previous doses of the requested medication has your patient tried?

What is your patient's current treatment plan (include target dose and titration plan)?

Can the prescriber attest that opioid therapy will be prescribed in accordance with current clinical practice guidelines? ☐ Yes ☐ No

Can the prescriber attest that an assessment of risks, harms, and goals consistent with an opioid agreement (or similar agreement) has been undertaken? ☐ Yes ☐ No

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:
Does your patient have a documented diagnosis of any of the following?
☐ active cancer treatment (defined as receiving antineoplastic or antitumor therapy)
☐ end of life care (including hospice or palliative care)
☐ sickle cell disease
☐ other (please specify):

Is there documentation that your patient has had failure or inadequate response to non-drug interventions to treat the source of their pain (examples: acupuncture, exercise, heat/ice therapy, massage, physical therapy, radiation, relaxation techniques, surgery, etc.)? ☐ Yes ☐ No

(if no) Is there documentation that your patient is not a candidate for non-drug interventions? ☐ Yes ☐ No

Is there documentation that your patient has had failure, inadequate response, or intolerance to non-opioid drugs to treat their pain (examples: acetaminophen, ibuprofen, muscle relaxants, drugs to treat nerve pain, etc.)? ☐ Yes ☐ No

(if no) Is there documentation that your patient has a contraindication per FDA label to or is not a candidate for any non-opioid drugs? ☐ Yes ☐ No

How is levorphanol being used?
☐ as-needed-basis for pain (**IR**)
☐ long-term, around-the-clock treatment for pain (**ER**)
☐ other (including pain that is NOT severe) (please specify):

For IR use:

Is your patient regularly taking opioid pain relievers on a daily basis (examples: morphine, hydrocodone, oxycodone, fentanyl, hydromorphone, naloxone, methadone)? ☐ Yes ☐ No (opioid naïve)

(if yes) For all opioids (short- and long-acting) that your patient has taken, please provide drug name and strength, dosing instructions, date(s) taken and for how long.

Which of the following immediate-release alternatives has your patient tried? Check all that apply.

☐ hydromorphone (generic Dilaudid)
☐ morphine (generic MSIR)
☐ oxycodone (generic OxyIR, Roxicodone)
☐ oxymorphone (generic Opana)
☐ hydrocodone/acetaminophen (generic Lorcet, Norco, Verdrocet, Vicodin, Xodol)
☐ oxycodone/acetaminophen (generic Percocet)
☐ none of the above

For each alternative checked as tried, please provide the following details: drug name, date(s) taken and for how long, and what the documented results were of taking each drug, including any documented intolerances or adverse reactions your patient experienced.

For all the alternatives NOT tried, is your patient able to try these drugs? ☐ Yes ☐ No

(if no) Please document all contraindications per FDA label that your patient has to using each of the alternatives NOT tried, including any reasons your patient is not a candidate to use those alternatives.

For ER use:

*****This use requires supportive documentation (opioid agreement, chart notes, lab/test results, etc) for all answers*****

Is there documentation that your patient has pain that is severe enough to require daily, around-the-clock, long-term opioid treatment? ☐ Yes ☐ No

Is there documentation that your patient has had failure, inadequate response or intolerance to a minimum one week trial of immediate-release opioids? *(examples of these include hydromorphone [Dilaudid], morphine [MSIR], oxycodone [Roxicodone], oxymorphone [Opana], hydrocodone/acetaminophen [Lorcet, Norco, Verdrocet, Vicodin, Xodol], oxycodone/acetaminophen [Percocet])*. ☐ Yes ☐ No

(if no) Is there documentation that your patient has a contraindication per FDA label to or is not a candidate for any non-opioid drugs? ☐ Yes ☐ No

(if yes) Please document all contraindications per FDA label that your patient has to a minimum one week trail of immediate-release opioids, including any reasons your patient is not a candidate to use these alternatives.

Which of the following long-acting alternatives has your patient tried? Check all that apply.

☐ Arymo ER
☐ Embeda
☐ Exalgo
☐ hydromorphone ER
☐ Kadian
☐ methadone
☐ Morphabond ER
☐ morphine ER
☐ MS Contin
☐ Nucynta ER
☐ Oxycontin
☐ oxymorphone ER
☐ Zohydro ER
☐ other (please specify):

For each alternative checked as tried, please provide the following details: drug name, date(s) taken and for how long, and what the documented results were of taking each drug, including any documented intolerances or adverse reactions your patient experienced:

For all the alternatives NOT tried, is your patient able to try those drugs? ☐ Yes ☐ No

(if no) Please document any reasons your patient is not able to use each of the alternatives NOT tried.

Is there an opioid therapy management agreement signed by the patient? ☐ Yes ☐ No

Additional pertinent information: (*please include other clinical reasons for drug, relevant lab values, etc.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

V090120

Address: Cigna Pharmacy Services, PO Box 42005, Phoenix AZ 85080-2005