TRICARE Prior Authorization Request Form for
Tapentadol ER (**Nucynta ER**)

JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:	______	Physician Name:	______
Address:	______	Address:	______
	______		______
Sponsor ID #	______	Phone #:	______
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

Question		
1. This agent has been identified as having cost-effective alternatives including the following: tapentadol IR, gabapentin, tramadol and several other immediate release opioids. These agents are available without a PA. Please consider changing the prescription to one of these agents.	**proceed to question 2**	
2. Is the patient 18 years of age or older?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. For which diagnosis is the requested medication being prescribed?	☐ Pain severe enough to require daily, around-the-clock, long-term opioid treatment - **Proceed to question 4** ☐ Neuropathic pain associated with diabetic peripheral neuropathy in adults severe enough to require daily, around-the-clock, long-term opioid treatment - **Proceed to question 5** ☐ Other indication or diagnosis- **STOP- Coverage not approved**	
4. Has the patient tried and failed at least ONE of the following short-acting opioids: morphine sulfate IR, codeine IR, hydromorphone IR, meperidine IR, oxycodone IR, hydrocodone/acetaminophen, oxycodone/acetaminophen, codeine/acetaminophen, tapentadol IR?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed, or had a contraindication to at least TWO of the following classes of non-opioid medications (unless the patient has a contraindication): • **gabapentin or pregabalin titrated to therapeutic dose,** • **tricyclic antidepressant titrated to therapeutic dose, or** • **duloxetine titrated to therapeutic dose?**	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**

6. Has the patient tried and failed Tramadol?	☐ Yes **Proceed to question 7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed at least ONE of the following short acting opioids: morphine sulfate IR, codeine IR, hydromorphone IR, meperidine IR, oxycodone IR, hydrocodone/acetaminophen, oxycodone/acetaminophen, codeine/acetaminophen, tapentadol IR?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_______________________________ Prescriber Signature   __________ Date

[03 Mar 2021]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: