



**Onsolis® Prior Authorization Request Form**

Please fax the completed request form to Mercy Health Plans Pharmacy Department  
at 314-214-8201 or 800-647-2240. For additional information please call 314-214-8282 or 800-647-2240.

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Patient Pharmacy ID: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (located on bottom right of insurance card)  
 Requesting Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 (Please print)  
 Office Contact Person: \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ ext \_\_\_\_  
 Office Address: \_\_\_\_\_  
 Medication/dose Requested: \_\_\_\_\_ Fax #: (\_\_\_\_)\_\_\_\_-\_\_\_\_  
 Expected Duration of Therapy: \_\_\_\_\_ ICD-9: \_\_\_\_\_

Please circle YES or NO:

1. Does the patient have a diagnosis of cancer with breakthrough pain? YES NO  
 Is the patient 18 years of age or older? YES NO  
 Is the patient opioid naive? YES NO

If no, please list opioid therapies patient is currently taking, below.

Opioid Therapy	Dose	Date	Therapeutic Outcome

Is the patient intolerant to immediate-release opioids? YES NO

If yes, please list opioid therapies patient is intolerant to, below.

Opioid Therapy	Dose	Date	Therapeutic Outcome

Is the physician compliant with the ONSOLIS FOCUS program? YES NO

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**For Mercy Health Plans use only:**

Approved Length of Approval \_\_\_\_\_  
 Denied Reason for Denial \_\_\_\_\_

Reviewer's Signature: \_\_\_\_\_ Date Reviewed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Override Entered in  Caremark  CCMS for \_\_\_\_\_ - \_\_\_\_\_ by \_\_\_\_\_

Office Notified on \_\_\_\_\_; at \_\_\_\_\_ am/pm; by \_\_\_\_\_ spoke to \_\_\_\_\_