

Physician Request Form for Opioid Containing Products

Fax to Pharmacy Services at **978-313-8230**, or call **1-800-558-1655** to speak to a representative. **Form must be completed for processing.**



Patient name: _____ Patient ID: _____
Patient address: _____ Date of Birth: _____
City: _____ State: _____ Zip: _____
Prescriber name: _____ NPI: _____
Prescriber address: _____ Phone: _____
City: _____ State: _____ Zip: _____ Fax: _____
Contact name: _____
Prescriber specialty: _____

Requested drug name, strength and dosage form: _____
Directions: _____ Duration of therapy: _____
Diagnosis: _____
Does the patient have cancer, sickle cell or are they in hospice? Yes No
Is the prescriber a Pain Specialist, Oncologist, Hospice Physician, Hematologist, or Surgeon? Yes No
If no, is the prescriber working in consultation with one of the above specialists? Yes No
If yes, please indicate the type of specialist: _____

FOR INITIAL REQUESTS

Prescriber attests to the following:

- For long-acting products, the diagnosis is chronic pain and requires daily, around the clock, opioid medication. Yes No
- The patient has tried and failed non-pharmacologic treatment and two non-opioid containing pain medications (ex. acetaminophen, NSAIDs, selected antidepressants, anticonvulsants). Yes No
- If the request is for a dose or day supply greater than the current restriction, provide documentation of medical necessity for the requested dose below or submit along with this form. _____

- Is the patient taking concurrent benzodiazepines? Yes* No
** If yes, the prescriber attests to discussing the risks of using opioids and benzodiazepines concurrently with the patient Yes No
Provide documentation as to why concurrent use is necessary and outline a plan for tapering if appropriate: _____
_____*
- Is the patient taking concurrent muscle relaxants? Yes* No
** If yes, the prescriber attests to discussing the risks of using opioids and muscle relaxants concurrently with the patient Yes No
Provide documentation as to why concurrent use is necessary and outline a plan for tapering if appropriate: _____
_____*

- Does the patient have a high-risk condition as stated in the CDC guidelines (ex. sleep apnea or other causes of sleep-disordered breathing, patients with renal or hepatic insufficiency, older adults, pregnant women, patients with depression or other mental health conditions, and patients with alcohol or other substance use disorders)? Yes* No
*If yes, the prescriber attests to discussing heightened risks of opioid use and has educated the patient on naloxone use and has considered prescribing naloxone. Yes No
- The prescriber attests that urine drug screens will be completed every 6 months and if illicit drugs are found, the patient will be identified as high risk and the heightened risk of overdose will be explained to the patient. Yes No
- The prescriber attests to checking the Pennsylvania PDMP. Yes No
- The prescriber attests to discussing with the patient the level of risk for opioid abuse/overdose with the dose/duration prescribed and has the patient's signature on file acknowledging education. Yes No
- The prescriber attests to discussing concomitant psychological disease and risks associated with opioid overdose/abuse, and has the patient's signature on file acknowledging education. Yes No
- The prescriber attests to discussing history of substance abuse and the risks associated with opioid overdose/abuse, and has the patient's signature on file acknowledging education. Yes No
- The prescriber has provided a copy of a pain management agreement signed by the patient. Yes No*
*If no, is the member currently residing in a facility? Yes No
- **If the patient does not meet the above criteria, but is actively tapering off of opioids, provide the tapering plan and explain medical necessity below or submit along with this form.**

- If the request is for a non-formulary opioid, the patient must meet the above criteria and have a trial and failure or intolerance with three formulary medications (if available) used to treat the documented diagnosis. Please list medications:

Prescriber Signature: _____ Print Name: _____ Date: _____

FOR RENEWAL REQUESTS

Prescriber attests to the following:

- The dose requested has been titrated down from the initial authorization. Yes No*
* If no, provide documentation for the continued dosing above 90 Morphine Milligram Equivalents (MMEs) per day and above the days supply limits and a proposed plan for titration going forward or submit along with this form. _____

- Provide documentation of patient's pain improvement (i.e. improvement in severity level of pain) below or submit along with this form. _____

- Is the patient taking concurrent benzodiazepines? Yes* No
**If yes, the prescriber attests to discussing the risks of using opioids and benzodiazepines concurrently with the patient Yes No
Provide documentation as to why concurrent use is necessary and outline a plan for tapering if appropriate: _____*

- Is the patient taking concurrent muscle relaxants? Yes* No
**If yes, the prescriber attests to discussing the risks of using opioids and muscle relaxants concurrently with the patient Yes No
Provide documentation as to why concurrent use is necessary and outline a plan for tapering if appropriate: _____*

- The prescriber has provided urine drug screen (UDS) dates (every 6 months): UDS dates: _____

- Positive for illicit drugs? Yes* No
- Positive for opioids? Yes No**

**If illicit drugs are found, the prescriber attests to identifying the patient as high risk and explained the heightened risk of overdose to the patient. Yes No*

***If opioids are not found on the urine drug screen, provide documentation as to why the patient needs to continue therapy or submit along with this form. _____*

- The prescriber attests to checking the Pennsylvania PDMP. Yes No
- Does the patient have a high-risk condition as stated in the CDC guidelines (ex. sleep apnea or other causes of sleep-disordered breathing, patients with renal or hepatic insufficiency, older adults, pregnant women, patients with depression or other mental health conditions, and patients with alcohol or other substance use disorders)? Yes* No
**If yes, the prescriber attests to discussing heightened risks of opioid use and has educated the patient on naloxone use and has considered prescribing naloxone. Yes No*

Deliver to:

- Member's Home Physician's Office Member's Preferred Pharmacy Name/Phone#): _____
- I acknowledge that the member agrees with the pharmacy chosen for delivery of this medication.

Prescriber Signature: _____ **Print Name:** _____ **Date:** _____