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: ___________________________

Updated 5/2018
• 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 the patient’s 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 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: ____________________