Physician Request Form for Opioid Containing Products

Fax to Pharmacy Services at 1-855-446-7894 or call 1-866-935-8874 to speak to a representative.
Form must be complete 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: _____

Is the patient in hospice? ☐Yes ☐No

Is the patient a resident of a long-term care facility? ☐Yes ☐No

Does the patient have cancer? ☐Yes ☐No

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 ☐N/A

- The patient has tried and failed non-pharmacologic treatment and two non-opioid containing pain medications (ex. acetaminophen, NSAIDs, select antidepressants, anticonvulsants). ☐Yes * ☐No *If yes provide drug names:

  _____

- If the request is for a dose or day supply greater than the limit/restriction, provide documentation of medical necessity for the requested dose or submit along with this form.

  _____

- Is the patient taking a concurrent benzodiazepine? ☐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:

  _____

- The prescriber attests that a urine drug screen has been completed at baseline and will be completed every 6 months. 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 Minnesota Prescription Monitoring Program (PMP) for member history. ☐Yes ☐No

- The prescriber attests to discussing with the patient the level of risk for opioid abuse/overdose with the dose/duration prescribed. ☐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

- The prescriber attests that the member has entered into a pain management agreement. ☐Yes ☐No*
  **If no, is the member currently residing in a facility?* ☐Yes ☐No

- If the request is for a non-formulary opioid, the patient must meet the above criteria and have a trial and failure or intolerance of at least two formulary opioid medications (if available). Please list medications:

_____

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

FOR RENEWAL REQUESTS

Prescriber attests to the following:

- The dose requested has been decreased since the previous authorization. ☐Yes ☐No*
  ** If no, provide documentation for the continued dosing above 90 Morphine Milligram Equivalents (MMEs) per day and/or above the 7 day supply limit and a proposed plan for titration going forward*

_____

- 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 a concurrent benzodiazepine? ☐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:

_____

- The prescriber has provided a copy of at least one urine drug screen (UDS) since the previous authorization (every 6 months): UDS date(s) (please submit results):

_____

  - 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 hightened 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 Minnesota Prescription Monitoring Program (PMP) for member history. ☐ Yes ☐ No

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

Add Additional Information here