

Physician Request Form for Opioid Containing Products

Fax to Pharmacy Services at 1-855-829-2872, or call 1-855-251-0966 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: _____
Is the prescriber a board certified 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: _____

Does the patient have cancer, sickle cell or are they in hospice? Yes No
Diagnosis: _____
Requested drug name, strength and dosage form: _____
Directions: _____ Duration of therapy: _____

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
- For long acting products, the prescriber attests that the member is treatment experienced with a history of short acting opioids. 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 in addition to the current pain regimen (i.e. medication name, strength, duration) below or submit along with this form. _____

- Has the patient tried non-pharmacological treatment for their pain? Yes No
- Has the patient tried at least two non-opioid containing pain medications? Yes No
Please list the non-opioid containing pain medications that have been tried: _____

- Is the patient taking a benzodiazepine? Yes* No
 *If yes, the prescriber attests to discussing the risks of using opioids and benzodiazepines together with the patient: Yes No
 Provide documentation as to why the use of an opioid and benzodiazepine is necessary: _____

- Is the patient taking a muscle relaxant? Yes* No
 *If yes, the prescriber attests to discussing the risks of using opioids and muscle relaxants together with the patient: Yes No
 Provide documentation as to why the use of an opioid and muscle relaxant is necessary: _____

- 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 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 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 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
- The prescriber attests to checking the Delaware PDMP for patient history. Yes No
- If the request is for a non-preferred opioid, the patient must meet the above criteria and have a trial and failure or intolerance with at least two preferred opioid medications. Please list medications tried: _____

Prescriber Signature: _____ Print Name: _____ Date: _____

FOR RENEWAL REQUESTS

Prescriber attests to the following:

- The dose requested has been titrated down from the previous authorization. Yes No*
 * If no, provide an explanation for the continued dosing at the requested amount or a proposed plan for titration going forward.

- Is the patient taking a benzodiazepine? Yes* No
 *If yes, the prescriber attests to discussing the risks of using opioids and benzodiazepines together with the patient Yes No
 Provide documentation as to why the use of an opioid and a benzodiazepine is necessary: _____

- Is the patient taking a muscle relaxant? Yes* No

**If yes, the prescriber attests to discussing the risks of using opioids and muscle relaxants together with the patient* Yes No

Provide documentation as to why the use of an opioid and a muscle relaxant is necessary: _____

- The prescriber has provided urine drug screen (UDS) dates (every 6 months): UDS dates: _____
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- 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 Delaware PDMP for patient history. 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

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