Opioids

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested: ICD10:

Strength:
Dosing instructions:
Quantity per month requested:
Expected duration:

Is the prescriber a board certified pain management specialist? ☐ Yes ☐ No
(if no) Is this drug being prescribed in coordination with a board certified pain management specialist? ☐ Yes ☐ No
Is the prescriber an oncologist or psychiatrist? ☐ Yes ☐ No

Do you attest that the history of controlled substance prescriptions has been checked using the state prescription drug monitoring program (PDMP)? ☐ Yes ☐ No

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ active cancer treatment (defined as receiving antineoplastic or antitumor therapy) requiring treatment for cancer-related pain
☐ end-of-life care (including hospice or palliative care)
☐ opioid addiction and receiving medication-assisted treatment addiction (this applies to methadone only)
☐ sickle cell disease
☐ none of the above (please specify):

(if end of life care or active cancer treatment) Is this a new start or continuation of therapy with the requested drug? If your patient has already begun treatment with drug samples, please choose "new start of therapy".
☐ new start of therapy ☐ continuation of therapy

Clinical Information:

For **levorphanol** only:
How is levorphanol being used?
☐ as-needed-basis for pain (IR) (Please answer IR questions below)
☐ long-term, around-the-clock treatment for pain (ER) (Please answer ER questions below)
☐ other (please explain):

If requesting an injectable opioid (alfentanil, hydromorphone, meperidine, methadone, morphine, remifentanil, sufentanil):
****Requires supportive documentation (chart notes, etc) be attached with this request****

What is the diagnosis related to pain? Please provide details of the type of pain and pathology.

Has the cause and pathology of the pain been documented (for example, an objective basis for the pain complaint)? ☐ Yes ☐ No
Did your patient have failure of at least 6 months of noninvasive pain management, including active rehabilitative exercises? ☐ Yes ☐ No
Is there documentation that your patient has tried and had failure or intolerance to other forms of opioid therapy [for example, oral (tablet, capsule, liquid, transmucosal), suppository or patch]? ☐ Yes ☐ No
(if no) Is there documentation that the above listed opioid formulations would NOT provide sufficient pain management for your patient? ☐ Yes ☐ No
Please provide details:

Is your patient currently taking any opioid pain relievers on a regular daily basis (examples: fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, oxymorphone)? This includes all long-acting, extended-release, short-acting or immediate-release formulations. ☐ Yes ☐ No (opioid naïve) ☐ Unknown

(if yes) Please provide the drug names and strength, dosing instructions, date(s) taken and for how long.

Does the patient's required daily dosage for pain management exceeds 60 MME (morphine milligram equivalents)? ☐ Yes ☐ No

If requesting any immediate-release formulation (IR) of ANY opioid:
Is your patient taking any opioids for pain (examples: fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, oxymorphone)? ☐ Yes ☐ No (opioid naïve)

(if yes) For all opioids that your patient has taken, please provide the following details: drug name, date(s) taken and for how long, and what the documented results were of taking each drug, including any documented intolerances or adverse reactions your patient experienced.

Is there documentation that your patient had a documented failure, contraindication, or intolerance to any of the following immediate-release/short-acting opioids? Check all that apply. (Intolerance means the patient had an adverse effect from the drug).

☐ hydromorphone
☐ hydrocodone/acetaminophen
☐ morphine
☐ oxycodone
☐ oxycodone/acetaminophen
☐ oxymorphone
☐ none of the above

For the alternatives tried, please include drug name and strength, date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

Please document all contraindications per FDA label that your patient has to using each of the alternatives NOT tried, including any reasons your patient is not a candidate to use those alternatives.

(if **opioid naive**) For which use is your patient being prescribed opioids?

☐ management of ACUTE DENTAL pain (for example, pain lasting less than 90 days)
☐ management of ACUTE NON-DENTAL pain (for example, pain lasting less than 90 days)
☐ management of CHRONIC pain (for example, pain lasting more than 90 days)
☐ unknown

(if **acute dental** pain) Do you attest that it is medically necessary for your patient to be initially treated with a regimen exceeding 3 days (for example, patient is not a candidate for less than 3 days **of therapy)?** ☐ Yes ☐ No

(if **acute non-dental** pain) Do you attest that it is medically necessary for your patient to be initially treated with a regimen exceeding 7 days (for example, patient is not a candidate for less than 7 days of therapy)? ☐ Yes ☐ No

(if **chronic** pain) Is there documentation that your patient has had failure, contraindication, or intolerance to non-opioid pharmacologic therapies intended to treat pain? ☐ Yes ☐ No

(if **chronic** pain) Do you attest that opioid therapy will be prescribed in accordance with current clinical practice guidelines? ☐ Yes ☐ No

(if **chronic** pain) Do you attest that an assessment of risks, harms, and goals consistent with an opioid agreement (or comprehensive treatment plan) has been undertaken? ☐ Yes ☐ No

(if Prolate oral solution or oxycodone/acetaminophen 5mg/325 mg oral solution) Is your patient unable to swallow tablets? ☐ Yes ☐ No

(If Qdolo or tramadol solution) Is your patient unable to swallow tramadol 50 mg IR tablets? ☐ Yes ☐ No

(if Roxicodone, Dilaudid oral tablet/solution, Hycodan oral tablet/solution, Percocet) Has your patient tried bioequivalent generic product, but had an allergic or adverse reaction? ☐ Yes ☐ No

(if yes) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the brand and bioequivalent generic products (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if yes) Please provide details to support.

(if Seglentis) Is your patient unable to use tramadol tablets and celecoxib capsules concurrently? ☐ Yes ☐ No

(if yes) Please provide details to support.

(if tramadol 100 mg tablets) Does your patient have a documented intolerance or inability to use tramadol 50 mg IR tablets? ☐ Yes ☐ No

(if yes) Please provide details to support.

(if Roxybond) Does your patient require an abuse-deterrent short-acting opioid? ☐ Yes ☐ No

If requesting any extended-release formulation (ER) of ANY opioid:

****Requires supportive documentation (chart notes, etc.) be attached with this request****

Is your patient taking long-acting/extended-release opioids for pain? These include: Duragesic, fentanyl patches, hydromorphone ER, Hysingla ER, morphine sulfate ER, MS Contin, Nucynta ER, oxycodone ER, Oxycontin, oxymorphone ER, Xtampza ER.
☐ Yes ☐ No (opioid naïve)

(if yes) For all opioids that your patient has taken, please provide drug name and strength, dosing instructions, date(s) taken and for how long.

Is there documentation that your patient has pain severe enough to require long-term treatment with daily, around-the-clock opioids? ☐ Yes ☐ No

Is there documentation that your patient tried and had failure, or intolerance to a minimum one-week trial of immediate-release opioids? ☐ Yes ☐ No

(if no) Is there documentation that your patient has a contraindication per FDA label to a minimum one-week trial of immediate-release opioids? ☐ Yes ☐ No

(if yes) Please explain the contraindications per FDA label or reasons that your patient cannot try at least one week of immediate-release opioids.

Is there documentation that your patient has had failure, contraindication, or intolerance to non-opioid pharmacologic therapies intended to treat pain? ☐ Yes ☐ No

Is there documentation that opioid therapy will be prescribed in accordance with current clinical practice guidelines? ☐ Yes ☐ No

Is there documentation that an assessment of risks, harms, and goals consistent with an opioid agreement (or comprehensive treatment plan) has been undertaken? ☐ Yes ☐ No

Is there documentation that your patient had a documented failure, contraindication, or intolerance to any of the following opioids? Check all that apply. (Intolerance means the patient had an adverse effect from the drug)

☐ hydrocodone bitartrate ER
☐ hydromorphone ER
☐ Hysingla ER
☐ oxymorphone ER
☐ tramadol 50 mg tablets (immediate release)
☐ tramadol 100 mg, 200 mg, OR 300 mg extended-release tablets
☐ Xtampza ER
☐ none of the above

For each alternative checked as tried, please provide the following details: drug name, date(s) taken and for how long, and what the documented results were of taking each drug, including any documented intolerances or adverse reactions your patient experienced:

Please document all contraindications per FDA label that your patient has to using each of the alternatives NOT tried, including any reasons your patient is not a candidate to use those alternatives.

(if MS Contin or Hysingla ER) Has your patient tried bioequivalent generic product, but had an allergic or adverse reaction? ☐ Yes ☐ No

(if yes) Is there documentation that this reaction was due to a formulation difference in the inactive ingredients between the brand and bioequivalent generic products (for example, difference in dyes, fillers, preservatives)? ☐ Yes ☐ No

(if yes) Please provide details to support.

For **methadone, Duragesic and fentanyl patches** only:

****Requires supportive documentation (chart notes, etc.) be attached with this request****

Is your patient currently taking any opioid pain relievers on a regular daily basis (examples: fentanyl, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, oxymorphone)? ☐ Yes ☐ No (opioid naïve)

(if yes) Please provide the drug names and strength, dosing instructions, date(s) taken and for how long.

Does the patient's required daily dosage for pain management exceeds 60 MME (morphine milligram equivalents)? ☐ Yes ☐ No

Is there documentation that your patient has pain severe enough to require long-term treatment with daily, around-the-clock opioids? ☐ Yes ☐ No

Is there documentation that your patient tried and had failure or intolerance to a minimum one-week trial of immediate-release opioids? ☐ Yes ☐ No

(if no) Is there documentation that your patient has a contraindication per FDA label to a minimum one week trial of immediate-release opioids? ☐ Yes ☐ No

(if yes) Please explain the contraindications per FDA label or reasons that your patient cannot try at least one week of immediate-release opioids.

Is there documentation that your patient tried alternative treatment options [for example, oral (tablet, capsule, liquid, transmucosal), suppository or transdermal opioid therapy] and these alternatives were ineffective or not tolerated? ☐ Yes ☐ No

(if no) Is there documentation that the above listed treatment options would NOT provide sufficient pain management for your patient? ☐ Yes ☐ No

Please provide details:

Is there documentation that opioid therapy will be prescribed in accordance with current clinical practice guidelines? ☐ Yes ☐ No

Is there documentation that an assessment of risks, harms, and goals consistent with an opioid agreement (or comprehensive treatment plan) has been undertaken? ☐ Yes ☐ No

For **Daily dose of all opioid analgesics exceeds 120 or 200 morphine milligram equivalents (120 or 200 MME)** only:

****Requires supportive documentation (chart notes, etc.) be attached with this request****

Is there documentation that your patient has had failure, contraindication, or intolerance to non-opioid pharmacologic therapies intended to treat pain? ☐ Yes ☐ No

Is there documentation that opioid therapy will be prescribed in accordance with current clinical practice guidelines? ☐ Yes ☐ No

Is there documentation that an assessment of risks, harms, and goals consistent with an opioid agreement (or comprehensive treatment plan) has been undertaken? ☐ Yes ☐ No

Is there documentation that the provider has performed a quarterly reassessment of opioid therapy benefits/risks specific to the patient's diagnosis and treatment goals? ☐ Yes ☐ No

Is there documentation that the provider has considered additional precautions that are intended to reduce the risk of serious harm associated with high dose opioids (for example, education and provision of naloxone)? ☐ Yes ☐ No

Is there documentation that the provider has performed an individualized behavioral health screening to assess the risks and benefits of the opioid dose (for example: Patient Health Questionnaire 9-item [PHQ-9], Generalized Anxiety Disorder 7-item scale [GAD-7], Primary Care PTSD Screen [PC-PTSD])? ☐ Yes ☐ No

Is there documentation that the provider has screened for substance abuse risk to assess the risks and benefits of the opioid dose (for example: Diagnosis, Intractability, Risk, Efficacy [DIRE], Opioid Risk Tool [ORT], Prescription Drug Use Questionnaire [PDUQ], Patient Medication Questionnaire [PMQ])? ☐ Yes ☐ No

Additional pertinent information: (*please include other clinical reasons for drug, relevant lab values, etc.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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