Federal Employee Program.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

EXTENDED RELEASE (ER) OPIOIDS
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information** (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: Male Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: R			Physician Signature:		

PHYSICIAN COMPLETES

*****The CDC's Opioid Guideline Mobile App is designed to help providers with Morphine Milligram Equivalent (MME) calculations when prescribing opioids. The CDC app is available for free download on Google Play for Android devices and in the Apple Store for iOS devices*****

NOTE: Form must be completed in its **entirety** for processing

Select Drug:	**Drug Strength:**	**Dosing Directions:**	**Requested Quantity per 90 days**
❑**Arymo (morphine ER)**			**qty __________ per 90 days**
❑**Avinza (morphine ER)**			**qty __________ per 90 days**
❑**Belbuca (buprenorphine ER)**			**qty __________ per 90 days**
❑**Embeda (morphine/naltrexone ER)**			**qty __________ per 90 days**
❑**Exalgo (hydromorphone ER)**			**qty __________ per 90 days**
❑**Hysingla ER (hydrocodone ER)**			**qty __________ per 90 days**
❑**Kadian (morphine ER)**			**qty __________ per 90 days**
❑**MorphaBond (morphine ER)**			**qty __________ per 90 days**
❑**MS Contin (morphine ER)**			**qty __________ per 90 days**
❑**Nucynta ER (tapentadol ER)**			**qty __________ per 90 days**
❑**Opana ER (oxymorphone ER)**			**qty __________ per 90 days**
❑**OxyContin (oxycodone ER)**			**qty __________ per 90 days**
❑**Tramadol ER (Conzip/Ultram ER)**			**qty __________ per 90 days**
❑**Xtampza ER (oxycodone ER)**			**qty __________ per 90 days**
❑**Zohydro ER (hydrocodone ER)**			**qty __________ per 90 days**

*****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Will the patient be using the ER opioid concurrently with Lucemyra, Methadone (Dolophine), or a Buprenorphine medication such as Suboxone for opioid addiction? ❑Yes* (**If YES,* please select Buprenorphine, Lucemyra, or Methadone below) ❑No
   - ❑**Lucemyra**
   - ❑**Buprenorphine:** Please answer the following questions:
     a. Has the patient had a recent injury, accident, or surgery that requires the addition of an opioid to their therapy? ❑Yes ❑No
     b. Do you agree the patient will be tapered off of the opioid within 30 days? ❑Yes* ❑No
     **If YES*, specify medication(s), strength, and quantity needed for the 30 day taper:
     ____
   - ❑**Methadone:** Do you agree the patient will be tapered off of the methadone or the requested opioid within 30 days? ***Select answer below:***
     ❑**Methadone**: Specify medication, strength, and quantity being requested for 30 days:
     ____
     ❑**Opioid:** Specify medication(s), strength, and quantity being requested for 30 days:
     ____
     ❑**No**: Specify strength and quantity needed for a 30 day supply: ______________________________

2. Is the **prescribing physician** a board certified oncologist? ❑Yes ❑No

3. Is the patient experiencing pain that is severe enough to require daily, around-the-clock long term opioid treatment? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITONAL QUESTIONS

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. ER Opioids – FEP MD Fax Form Revised 1/1/2021

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: ___________________________ **DOB:** ____________________ **Cardholder ID:** ____________________________

4. Does the prescriber agree to assess the patient for the benefits of the pain control, for example, by implementing a care plan, monitoring for signs of misuse/abuse using standard lab screening (i.e. urine, blood) and evaluating severity of pain after three months? ❑Yes ❑No
5. Will the patient be assessed for signs and symptoms of serotonin syndrome? ❑Yes ❑No
6. Will the patient be concurrently using the requested medication in combination with alprazolam (Xanax), clonazepam (Klonopin), diazepam (Valium), or lorazepam (Ativan)? ❑Yes ❑No
7. Will the patient be concurrently using the requested medication in combination with oxazepam (Serax), chlordiazepoxide (Librium), or clorazepate dipotassium (Tranxene)? ❑Yes ❑No
8. Does the prescriber agree to participate in the *Opioid Analgesic REMS program and to monitor for abuse, misuse, addiction and overdose and discontinue if necessary? ❑Yes ❑No

   ***For information about Opioid Analgesic REMS please visit*: https://opioidanalgesicrems.com**
9. Has the patient received the requested medication within the past 180 days? ❑Yes ❑No*

   ***If NO**, has the patient previously been treated with at least 10 days of an immediate-release (IR) opioid in the last 90 days or is switching from another long-acting opioid? ❑Yes ❑No
10. Have alternative treatment options, including non-opioid analgesics and opioid immediate-release analgesics, been ineffective, not tolerated or inadequate at controlling the patient's pain? ❑Yes ❑No
11. Will the patient be taking the requested medication with another extended-release (ER) opioid analgesic? ❑Yes* ❑No

    ***If YES**, please specify medication, strength, and quantity per 90 days: ____
12. Does the patient's current opioid pain regimen exceed 300 morphine milligram equivalents (MME) per day? ❑Yes* ❑No

    ***If YES**, please answer the following questions:

    a. Is the patient currently taking an immediate release (IR) opioid? ❑Yes* ❑No

    ***If YES**, please specify all drugs, strengths, and quantities for each IR opioid:

    ____

    ____

    b. Is the patient currently taking an extended release (ER) opioid? ❑Yes* ❑No

    ***If YES**, please specify all drugs, strengths, and quantities for each ER opioid:

    ____

    ____

    c. Is the patient's opioid regimen being adjusted from established therapy? ***Please select answer below:***

    ❑**YES**: Please select one of the following below:

    - ❑ This is a change of therapy to a different drug or strength from established therapy. Please specify drug that is being replaced: ____
    - ❑ This is a request to increase quantity for an opioid the member is established on
    - ❑ This is a change of therapy to add a new drug or strength to established therapy

    ❑**NO**: The patient is continuing on their currently established opioid regimen

    d. Does the physician agree that the patient's opioid regimen will be tapered to 300MME? ❑Yes* ❑No

    ***If YES**, please specify which drug will be tapered and what the final quantity will be in a 90 day supply:

    ____

    ____

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