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

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

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)
☐ end-of-life care (including hospice or palliative care)
☐ opioid addiction and receiving medication-assisted treatment
☐ sickle cell disease
☐ none of the above (please specify):

(if end of life care) 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 ☐ continued therapy

Clinical Information:

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

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

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.

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 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 (generic Dilaudid)
☐ hydrocodone/acetaminophen (generic Lorcet, Norco, Vicodin, Xodol)
☐ morphine (generic MSIR)
☐ oxycodone (generic OxyIR, Roxicodone)
☐ oxycodone/acetaminophen (generic Percocet)
☐ oxymorphone (generic Opana)
☐ Roxybond
☐ none of the above

Is there a documented reason that your patient is not a candidate for or is unable to use (including contraindication per FDA label) any of the following immediate-release/short-acting opioids? Check all that apply.
☐ hydromorphone (generic Dilaudid)
☐ hydrocodone/acetaminophen (generic Lorcet, Norco, Vicodin, Xodol)
☐ morphine (generic MSIR)
☐ oxycodone (generic OxyIR, Roxicodone)
☐ oxycodone/acetaminophen (generic Percocet)
☐ oxymorphone (generic Opana)
☐ Roxybond
☐ none of the above

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) Is there documented attestation 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-denta**l pain) Is there documented attestation 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, inadequate response, or intolerance to non-opioid drugs to treat their pain (examples: acetaminophen, ibuprofen, muscle relaxants, drugs to treat nerve pain, etc.)?
☐ Yes ☐ No

(if no) Is there documentation that your patient has a contraindication per FDA label to or is not a candidate for any non-opioid drugs?
☐ Yes ☐ No

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

(if **chronic** pain) Can the prescriber attest that an assessment of risks, harms, and goals consistent with an opioid agreement (or similar agreement) has been undertaken?
☐ Yes ☐ No

If requesting any extended-release formulation (ER) of ANY opioid:
Is your patient taking long-acting/extended-release opioids for pain? These include: Arymo ER, Duragesic, Embeda, Exalgo, fentanyl patches, hydromorphone ER, Hysingla ER, Kadian, Morphabond ER, morphine sulfate ER, MS Contin, Nucynta ER, oxycodone ER, Oxycontin, oxymorphone ER, Xtampza ER, Zohydro 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, inadequate response or intolerance to a minimum one week trial of immediate-release opioids (examples: hydromorphone [Dilaudid], hydrocodone/acetaminophen [Lorcet, Norco, Vicodin, Xodol], morphine [MSIR], oxycodone [Roxicodone], oxycodone/acetaminophen [Percocet], oxymorphone [Opana])? ☐ Yes ☐ No

(if no) Is there documentation that your patient has a contraindication per FDA label to or is not a candidate for 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 of an opioid therapy management agreement signed by BOTH the patient and prescribing clinician?
☐ Yes ☐ No **^^MUST BE FAXED IN WITH THIS FORM^^**

Which of the following alternatives has your patient tried? Check all that apply.
☐ Hysingla ER
☐ Morphabond ER
☐ 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:

Per the above, did your patient have documented FAILURE or INTOLERANCE to any of the following: Hysingla ER, Morphabond ER, Xtampza ER? Note: intolerance means the patient had an adverse effect from the drug.
☐ Yes, to ALL 3 of these
☐ Yes, to only 1 or 2 of these
☐ No, none of these

(if 1, 2 or no) If your patient has NOT tried Hysingla ER, Morphabond ER, Xtampza ER, is your patient able to try these drugs? ☐ Yes ☐ No

(if no) Please document any reasons your patient is not able to use each of the alternatives NOT tried.

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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