Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

Medicare D Request for Opioid Therapy Evaluation

FAX 1-800-956-2397

Patient Name: (Please Print)	
Patient ID Number:	**Patient Birthdate:**
MD Name:	**MD Specialty:**
MD Phone #:	**MD Fax #:**
MD NPI#	

For more information on the point of sale opioid edits, the policy, ***Medicare Part D Formulary-Level Opioid POS Edits***, can be viewed at https://www.excellusbcbs.com/wps/portal/xl/prv/drg/policies/

Requested Drug Name: _____

Diagnosis:_____

☐ New Start ☐ Continued Therapy StartDate:_____

Please list all of the opioids that the patient is currently taking to treat their pain:

_____

_____

_____

☐ **I attest that ALL of the opioids in the patient's treatment regimen listed above are necessary and appropriate.**

Please list all previous therapies that the patient has attempted and their outcomes:

Drug Name_____Dates of Use____to____Outcome_____

Drug Name_____Dates of Use____to____Outcome_____

Drug Name_____Dates of Use____ to____Outcome_____

Please indicate the MME dose warranted to adequately manage the patient's pain. (For additional information on calculating the morphine milligram equivalent (MME) dose for a patient taking one or more opioid medications, please refer to https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-vFeb-2018.pdf OR https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf). Online calculators/apps, such as the *CDC Opioid Guidenline App*, are also available to assist in calculating a total MME amount.

(NOTE: The accumulated MME amount that you select below will be the new limit at which the patient's opioid prescription(s) will be subject to. The patient will require another coverage determination once they exceed the newly selected limit.)

___The provider attests that no maximum limit for accumulated MME per day be set for this patient
___The provider attests that this patient be limited to a maximum accumulated MME dose up to 1000 mg/day
___The provider attests that this patient be limited to a maximum accumulated MME dose of up to 800mg/day
___The provider attests that this patient be limited a maximum accumulated MME dose of _____mg/day

I certify that the above information is true and accurate to the best of my knowledge. Please add your electronic signature below or print this document and provide your handwritten signature to avoid delays.

Provider Signature:_____Date: _____

Fax the form to 1-800-956-2397
Urgent requests only: 1-800-208-4050 (fax)
For assistance in completing this form, call: 1-800-499-1275