EXCEPTION REQUEST FORM

Opioid MED Request - Medicare

Unless otherwise indicated below, authorization quantities are limited to the manufacturer recommended dosage

P.O. Box 30192
Salt Lake City, UT 84130-0192
SELECTHEALTH.ORG

Complete online at www.selecthealth.org/pa or fax back to: 801-650-3170

For questions or clarifications, call: 801-442-9988 or 855-442-9988

Patient Information	
Patient's Name:	Patient's Date of Birth:
Patient's ID:	Patient's Phone #:
Diagnosis Code(s):	
Requesting Provider Information	
Name:	Phone #:
NPI/DEA:	Fax #:
Address:	Supervising Physician (if requesting provider bills under a different provider)
	Name:
,	NPI/DEA:

Drug Name and Strength:	Directions / SIG:
☐ Urgent Request (24 hours)	☐ Standard Request (72 hours)

Q1. Which medication is being requested (please include medication name, strength, and dosage)?
Q2. Is the request for a brand name medication that has a commercially available generic equivalent? ☐ Yes ☐ No
Q3. If yes, please indicate why the generic equivalent cannot be used:
Q4. Does the patient have a diagnosis of cancer or reside in a hospice or palliative care center? ☐ Yes ☐ No
Q5. If no, please provide the member's diagnosis:

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Q6. Has the patient been stable on the dose requested?

☐ Yes ☐ No

Q7. If yes, please provide the duration of therapy:

Q8. Is this a request to increase the patient's current opioid regimen?

☐ Yes ☐ No

Q9. If yes, please indicate if this is a long-term or short-term increase (expected length of therapy) and provide medical rationale for the increase:

Q10. Have attempts been made to reduce the patients cumulative daily morphine equivalent opioid dose?

☐ Yes ☐ No

Q11. Has the patient tried and failed therapy with non-steroidal anti-inflammatory drugs (e.g. ibuprofen, meloxicam, naproxen, diclofenac, etodolac, etc.)?

☐ Yes ☐ No

Q12. If yes, please list the medication name(s), dosage, and duration of therapy:

Q13. Has the patient tried and failed therapy with long-acting opioid therapies (e.g. Oxycontin, MS Contin, oxymorphone ER, fentanyl patches, etc.)?

☐ Yes ☐ No

Q14. If yes, please list the medication name(s), dosage, and duration of therapy:

Q15. Has the patient tried and failed therapy with short-acting opioid therapies (e.g. Percocet, Norco, Percodan, Roxicodone, etc.)?

☐ Yes ☐ No

Q16. If yes, please list the medication name(s), dosage, and duration of therapy:

Q17. Has the patient tried and failed therapy with any other non-opioid interventions?

☐ Yes ☐ No

Q18. If yes, please list the medication name(s), dosage, and duration of therapy:

Q19. Aside from being stable on the requested dose (when applicable), please provide additional rationale for the member to receive opioid therapy at or above 200 morphine equivalents daily: (Note, the Centers for Disease Control and Prevention (CDC) has recommended that cumulative daily doses of 90 morphine equivalents or more should be avoided and should be carefully justified.)

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Q20. Chart notes or a letter of medical necessity are required for the request of this medication. Failure to provide them will result in a delay in decision and/or denial. Did you attach relevant chart notes and a letter of medical necessity?

☐ Yes ☐ No

Q21. Additional Comments:

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-0413. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

____ ___________________________________

Prescriber Signature Date

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