Physician Request Form for Opioid Containing Products
Fax to Pharmacy Services at **877-708-9080**, or call **800-578-0898**
to speak to a representative. ***Form must be completed for processing***.

AmeriHealth Caritas Pennsylvania

Patient name: _____ Patient ID: _____

Patient address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Prescriber name: _____ NPI: _____

Prescriber address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Contact name: _____

Prescriber specialty: _____

Requested drug name, strength and dosage form: _____

Directions: _____ Duration of therapy: _____

Diagnosis: _____

Does the patient have cancer, sickle cell or are they in hospice? ☐Yes ☐No

Is the prescriber a Pain Specialist, Oncologist, Hospice Physician, Hematologist, or Surgeon? ☐Yes ☐No

If no, is the prescriber working in consultation with one of the above specialists? ☐Yes ☐No

If yes, please indicate the type of specialist: _____

FOR INITIAL REQUESTS

Prescriber attests to the following:

- For long-acting products, the diagnosis is chronic pain and requires daily, around the clock, opioid medication. ☐Yes ☐No
- The patient has tried and failed non-pharmacologic treatment and two non-opioid containing pain medications (ex. acetaminophen, NSAIDs, selected antidepressants, anticonvulsants). ☐Yes ☐No
- If the request is for a dose or day supply greater than the current restriction, provide documentation of medical necessity for the requested dose below or submit along with this form. _____

  _____
- Is the patient taking concurrent benzodiazepines? ☐Yes* ☐No

  ** If yes, the prescriber attests to discussing the risks of using opioids and benzodiazepines concurrently with the patient* ☐ Yes ☐ No

  Provide documentation as to why concurrent use is necessary and outline a plan for tapering if appropriate: _____

  _____
- Is the patient taking concurrent muscle relaxants? ☐Yes* ☐No

  **If yes, the prescriber attests to discussing the risks of using opioids and muscle relaxants concurrently with the patient* ☐Yes ☐No

  Provide documentation as to why concurrent use is necessary and outline a plan for tapering if appropriate: _____

  _____

- Does the patient have a high-risk condition as stated in the CDC guidelines (ex. sleep apnea or other causes of sleep-disordered breathing, patients with renal or hepatic insufficiency, older adults, pregnant women, patients with depression or other mental health conditions, and patients with alcohol or other substance use disorders)? ☐Yes* ☐No
  **If yes, the prescriber attests to discussing heightened risks of opioid use and has educated the patient on naloxone use and has considered prescribing naloxone.* ☐Yes ☐No

- The prescriber attests that urine drug screens will be completed every 6 months and if illicit drugs are found, the patient will be identified as high risk and the heightened risk of overdose will be explained to the patient. ☐Yes ☐No

- The prescriber attests to checking the Pennsylvania PDMP. ☐Yes ☐No

- The prescriber attests to discussing with the patient the level of risk for opioid abuse/overdose with the dose/duration prescribed and has the patient's signature on file acknowledging eduation. ☐Yes ☐No

- The prescriber attests to discussing concomitant psychological disease and risks associated with opioid overdose/abuse, and has the patient's signature on file acknowledging eduation. ☐Yes ☐No

- The prescriber attests to discussing history of substance abuse and the risks associated with opioid overdose/abuse, and has the patient's signature on file acknowledging eduation. ☐Yes ☐No

- The prescriber has provided a copy of a pain management agreement signed by the patient. ☐Yes ☐No*
  **If no, is the member currently residing in a facility?* ☐Yes ☐No

- **If the patient does not meet the above criteria, but is actively tapering off of opioids, provide the tapering plan and explain medical necessity below or submit along with this form.**

  _____

  _____

- If the request is for a non-formualry opioid, the patient must meet the above criteria and have a trial and failure or intolerance with three formulary medications (if available) used to treat the documented diagnosis. Please list medications:

  _____

Prescriber Signature: _____ **Print Name:** _____ **Date**: _____

FOR RENEWAL REQUESTS

Prescriber attests to the following:

- The dose requested has been titrated down from the initial authorization. ☐Yes ☐No*
  ** If no, provide documentation for the continued dosing above 90 Morphine Milligram Equivalents (MMEs) per day and above the days supply limits and a proposed plan for titration going forward or submit along with this form.* _____

  _____

  _____

- Provide documentation of patient's pain improvement (i.e. improvement in severity level of pain) below or submit along with this form. _____

  _____

- Is the patient taking concurrent benzodiazepines? ☐Yes* ☐No
  **If yes, the prescriber attests to discussing the risks of using opioids and benzodiazepines concurrently with the patient* ☐Yes ☐No
  Provide documentation as to why concurrent use is necessary and outline a plan for tapering if appropriate: _____

  _____

- Is the patient taking concurrent muscle relaxants? ☐Yes* ☐No
  **If yes, the prescriber attests to discussing the risks of using opioids and muscle relaxants concurrently with the patient* ☐Yes ☐No
  Provide documentation as to why concurrent use is necessary and outline a plan for tapering if appropriate: _____

  _____

- The prescriber has provided urine drug screen (UDS) dates (every 6 months): UDS dates: _____

  _____

  - Positive for illicit drugs? ☐Yes* ☐No
  - Positive for opioids? ☐Yes ☐No**

    *If illicit drugs are found, the prescriber attests to identifying the patient as high risk and explained the hightened risk of overdose to the patient. ☐Yes ☐No

    **If opioids are not found on the urine drug screen, provide documentation as to why the patient needs to continue therapy or submit along with this form. _____

    _____

- The prescriber attests to checking the Pennsylvania PDMP. ☐Yes ☐No

- Does the patient have a high-risk condition as stated in the CDC guidelines (ex. sleep apnea or other causes of sleep-disordered breathing, patients with renal or hepatic insufficiency, older adults, pregnant women, patients with depression or other mental health conditions, and patients with alcohol or other substance use disorders)? ☐Yes* ☐No
  **If yes, the prescriber attests to discussing heightened risks of opioid use and has educated the patient on naloxone use and has considered prescribing naloxone.* ☐ Yes ☐ No

Deliver to:

☐Member's Home ☐Physician's Office ☐Member's Preferred Pharmacy Name/Phone#):_____

☐ I acknowledge that the member agrees with the pharmacy chosen for delivery of this medication.

Prescriber Signature: _____**Print Name:** _____**Date**: _____