

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax#: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Opioids – Medical Necessity Request
****Complete pages 1-3 for Initial Requests Only****

Contraindication Information (Please indicate if the member has any of the following contraindications for the requested drug):

Abstral, Lazanda, Subsys <input type="checkbox"/> Patients who are not opioid tolerant <input type="checkbox"/> Acute or postoperative pain including headache/migraines and dental pain, or acute pain in the emergency department <input type="checkbox"/> Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment <input type="checkbox"/> Known or suspected gastrointestinal obstruction, including paralytic ileus <input type="checkbox"/> NONE
Actiq, Fentora <input type="checkbox"/> Patients who are not opioid tolerant <input type="checkbox"/> Significant respiratory depression <input type="checkbox"/> Acute or postoperative pain including headache/migraines and dental pain, or acute pain in the emergency department <input type="checkbox"/> Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment <input type="checkbox"/> Known or suspected gastrointestinal obstruction, including paralytic ileus <input type="checkbox"/> NONE
Arymo ER, Conzip, Kadian, MS Contin, Ryzolt ER <input type="checkbox"/> Significant respiratory depression <input type="checkbox"/> Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment <input type="checkbox"/> Concurrent use of monoamine oxidase inhibitors (MAOIs) or use of MAOIs within the last 14 days <input type="checkbox"/> Known or suspected gastrointestinal obstruction, including paralytic ileus <input type="checkbox"/> NONE
Avinza <input type="checkbox"/> Significant respiratory depression <input type="checkbox"/> Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment <input type="checkbox"/> Known or suspected paralytic ileus <input type="checkbox"/> NONE
Belbuca, Butrans, Hysingla ER, Methadone, Oxycontin, Xtampza ER, Zohydro ER <input type="checkbox"/> Significant respiratory depression <input type="checkbox"/> Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment <input type="checkbox"/> Known or suspected gastrointestinal obstruction, including paralytic ileus <input type="checkbox"/> NONE
Duragesic <input type="checkbox"/> Patients who are not opioid-tolerant <input type="checkbox"/> Management of acute or intermittent pain or in patients who require opioid analgesia for a short period of time <input type="checkbox"/> Management of post-operative pain, including use after out-patient or day surgeries <input type="checkbox"/> Management of mild pain <input type="checkbox"/> Significant respiratory depression <input type="checkbox"/> Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment <input type="checkbox"/> Known or suspected gastrointestinal obstruction, including paralytic ileus <input type="checkbox"/> NONE

Physician office's signature* _____ Print Name _____

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Exalgo <input type="checkbox"/> Patients who are not opioid tolerant <input type="checkbox"/> Significant respiratory depression <input type="checkbox"/> Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment <input type="checkbox"/> Known or suspected gastrointestinal obstruction, including paralytic ileus <input type="checkbox"/> Patients who have had surgical procedures and/or underlying disease resulting in narrowing of the gastrointestinal tract or have "blind loops" of the gastrointestinal tract or gastrointestinal obstruction <input type="checkbox"/> NONE
Nucynta ER <input type="checkbox"/> Significant respiratory depression <input type="checkbox"/> Acute or severe bronchial asthma or hypercarbia in an unmonitored setting or in the absence of resuscitative equipment <input type="checkbox"/> Known or suspected gastrointestinal obstruction, including paralytic ileus <input type="checkbox"/> Concurrent use of monoamine oxidase inhibitors (MAOIs) or use of MAOIs within the last 14 days <input type="checkbox"/> NONE
Opana ER <input type="checkbox"/> Significant respiratory depression <input type="checkbox"/> Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment <input type="checkbox"/> Known or suspected gastrointestinal obstruction, including paralytic ileus <input type="checkbox"/> Moderate or severe hepatic impairment <input type="checkbox"/> NONE
Ultram ER <input type="checkbox"/> Significant respiratory depression <input type="checkbox"/> Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment <input type="checkbox"/> Concurrent use of monoamine oxidase inhibitors (MAOIs) or use of MAOIs within the last 14 days <input type="checkbox"/> Known or suspected gastrointestinal obstruction, including paralytic ileus <input type="checkbox"/> Children younger than 12 years of age <input type="checkbox"/> Postoperative management in children younger than 18 years of age following tonsillectomy and/or adenoidectomy <input type="checkbox"/> NONE

Diagnosis Information (please indicate the diagnosis and answer the related questions):

- What is the diagnosis?
 - Pain
 - Is the pain chronic? **Yes** or **No**
 - Is the pain severe enough to require daily around-the-clock long-term opioid treatment? **Yes** or **No**
 - Breakthrough pain related to underlying persistent cancer pain
 - Other: _____

General Questions (please answer the following questions):

- Is the member currently taking buprenorphine or buprenorphine/naloxone for the treatment of opioid dependence? **Yes** or **No**
 - If **yes**, what is the reason the member will be taking buprenorphine or buprenorphine/naloxone concurrently with opioid therapy? _____
- Can the member try an alternative treatment (such as non-opioid analgesics or immediate-release opioids)? **Yes** or **No**
 - If **yes**, please call the alternative medication prescription to the member's pharmacy
 - If **no**, please provide the clinical reason as to why below:
 - Member is receiving active cancer treatment, palliative care, or end-of-life care
 - Has tried the following alternatives (please provide reason for discontinuation): _____
 - _____
 - Other: _____

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4. Is the member already receiving opioid therapy? (NOTE: Examples of opioids include OxyContin, Percocet, etc.) **Yes or No**
- If **yes**, what opioid therapy is the member currently receiving and when was it last received? (include dose, directions and fill dates) _____

Additional Questions (please answer all corresponding questions for the requested drug):

<p>Abstral, Actiq, Fentora, Lazanda, Subsys</p> <p>a. Is the member currently receiving around-the-clock opioid therapy for underlying persistent cancer pain? Yes or No</p> <ul style="list-style-type: none"> - If yes, please provided the name, dose, directions of the opioids the member is receiving and the date last received: _____ _____ <p>b. Will the member continue around-the-clock opioids? Yes or No</p> <p>c. Will the member be managed by an oncologist or pain specialist? Yes or No</p>
<p>Arymo ER, Avinza, Belbuca, Butrans, Conzip, Exalgo, Hysingla ER, Kadian, MS Contin, Nucynta ER, Opana ER, OxyContin, Ryzolt ER, Ultram ER, Xtampza ER, Zohydro ER</p> <p>a. Is the member currently on or will the member be on any other long-acting opioid pain controller(s)? (i.e. Oxycontin, Avinza, MS Contin, Kadian, Duragesic, or Butrans) Yes or No</p> <ul style="list-style-type: none"> - If yes, which long-acting opioid pain controller(s) will the member be receiving concurrently? _____ - What is the clinical reason why the member is receiving more than one long-acting opioid pain controller? _____ - Please document any long-acting opioids that have been recently discontinued or will be discontinued if the requested medication is approved: _____
<p>Duragesic</p> <p>a. Is the member currently on or will the member be on any other long-acting opioid pain controller(s)? (i.e. Oxycontin, Avinza, MS Contin, Kadian, Duragesic, or Butrans) Yes or No</p> <ul style="list-style-type: none"> - If yes, which long-acting opioid pain controller(s) will the member be receiving concurrently? _____ - What is the clinical reason why the member is receiving more than one long-acting opioid pain controller? _____ - Please document any long-acting opioids that have been recently discontinued or will be discontinued if the requested medication is approved: _____ <p>b. How often will the Duragesic patch be applied?</p> <p><input type="checkbox"/> Every 72 hours</p> <p><input type="checkbox"/> Every 48 hours</p> <ul style="list-style-type: none"> - Has the member tried an every 72-hours regimen? Yes or No <li style="margin-left: 20px;">If yes: Was adequate pain control achieved using a 72-hour regimen? Yes or No <li style="margin-left: 40px;"><input type="checkbox"/> If yes, please provide the clinical reason for requesting an every 48 hour regimen if adequate pain control was achieved using an every 72 hour regimen: _____ <li style="margin-left: 40px;">_____ <li style="margin-left: 20px;">If no: Please provide the clinical reason why the member cannot try an every 72-hour regimen: _____ <li style="margin-left: 40px;">_____

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****Complete pages 4-5 only for Subsequent/Renewal requests****

1. What is the diagnosis?
 - Pain
 - Is the pain chronic? **Yes** or **No**
 - Is the pain severe enough to require daily around-the-clock long-term opioid treatment? **Yes** or **No**
 - Breakthrough pain related to underlying persistent cancer pain
 - Is the member already receiving and is tolerant to around-the-clock opioid therapy? **Yes** or **No**
 - Other: _____
2. Is the member currently taking buprenorphine or buprenorphine/naloxone for the treatment of opioid dependence? **Yes** or **No**
 - a. If **yes**, what is the reason the member will be taking buprenorphine or buprenorphine/naloxone concurrently with opioid therapy? _____

3. The request is for a:
 - Dose increase
 - What additional opioid medication(s) is the member currently taking that necessitates the dose increase? Include drug name, strength, directions, and date of last fill. (NOTE: Examples of opioids are Opana, Percocet, Dilaudid, etc.)

 - How long was the member on the previous dose? _____
 - Dose decrease
 - Dose remaining the same
4. Will the previous dose be discontinued? **Yes** or **No**

Additional Questions (Please answer all corresponding questions for requested drug):

Abstral, Actiq, Fentora, Lazanda, Subsys a. Will the member continue around-the-clock opioids? Yes or No b. Will the member be managed by an oncologist or pain specialist? Yes or No
Arymo ER, Avinza, Belbuca, Butrans, Conzip, Exalgo, Hysingla ER, Kadian, MS Contin, Nucynta ER, Opana ER, OxyContin, Ryzolt ER, Ultram ER, Xtampza ER, Zohydro ER a. Is the member currently on or will the member be on any other long-acting opioid pain controller(s)? (i.e. Oxycontin, Avinza, MS Contin, Kadian, Duragesic, or Butrans) Yes or No <ul style="list-style-type: none">- If yes, which long-acting opioid pain controller(s) will the member be receiving concurrently? _____ _____- What is the clinical reason why the member is receiving more than one long-acting opioid pain controller? _____
Duragesic a. Is the member currently on or will the member be on any other long-acting opioid pain controller(s)? (i.e. Oxycontin, Avinza, MS Contin, Kadian, Duragesic, or Butrans) Yes or No <ul style="list-style-type: none">- If yes, which long-acting opioid pain controller(s) will the member be receiving concurrently? _____

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- What is the clinical reason why the member is receiving more than one long-acting opioid pain controller?

b. How often will the Duragesic patch be applied?

Every 72 hours

Every 48 hours

- Has the member tried an every 72-hours regimen? **Yes or No**

- If **yes**: Was adequate pain control achieved on a 72-hour regimen? **Yes or No**

If **yes**, please provide the clinical reason for requesting an every 48 hour regimen if adequate pain control was achieved using an every 72 hour regimen: _____

- If **no**: Please provide the clinical reason why the member cannot try an every 72-hour regimen: _____

c. Has the member experienced an improvement in pain and function? **Yes or No**

- If **no**, please provide the prescriber's plan to improve the member's pain and function (e.g., taper medication with intention to discontinue, change in drug therapy or dose, maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate, and/or consult a pain management specialist) _____

Metadone

a. What is the diagnosis?

Chronic pain:

- Is the pain severe enough to require daily around-the-clock long-term opioid treatment? **Yes or No**

- Has the member experienced an improvement in pain and function? **Yes or No**

If **no**, please provide the prescriber's plan to improve the member's pain and function (e.g., taper medication with intention to discontinue, change in drug therapy or dose, maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate, and/or consult a pain management specialist) _____

Opioid withdrawal/Opioid Dependence

Other: _____

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