Physician Request Form for Opioid Containing Products
Fax to Pharmacy Services at **215-937-5018**, or call **1-800-588-6767**
to speak to a representative. ***Form must be completed for processing***.

Keystone First

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. _____

  _____
- The prescriber attests to checking the Pennsylvania PDMP. ☐Yes ☐No
- The member is not taking concurrent benzodiazepines. ☐Yes ☐No*
  ** If no, the prescriber attests to discussing the risks of using opioids and benzodiazepines concurrently with the patient, has provided documentation as to why concurrent use is necessary and has outlined a plan for tapering if appropriate.* ☐Yes ☐No
- The member is not taking concurrent muscle relaxants. ☐Yes ☐No *
  **If no, the prescriber attests to discussing the risks of using opioids and muscle relaxants concurrently, has provided documentation as to why concurrent use is necessary and has outlined a plan for tapering if appropriate.* ☐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

1. 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 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 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 to this request form.
  ☐Yes ☐No

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

  _____

  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

- **For those members who do not meet the above criteria, but are actively tapering off of opioids, the prescriber has provided and explained 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 one of the following conditions:
  1. Documented trial and failure or intolerance with up to three formulary medications used to treat the documented diagnosis. For medications where there is only one preferred agent, only that agent must have been ineffective or not tolerated. Please list medications: _____
  2. No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia.
  3. All other formulary medications are contraindicated based on the patient's diagnosis, other medical conditions, or other medication therapy.

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.* _____

  _____

  _____

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

- The prescriber has submitted documentation of patient's pain improvement (i.e. improvement in severity level of pain) _____

- The member is not taking concurrent benzodiazepines. ☐Yes ☐No*
  *If no, the prescriber attests to discussing the risks of using opioids and benzodiazepines concurrently with the patient, has provided documentation as to why concurrent use is necessary and has outlined a plan for tapering if appropriate.
  ☐Yes ☐No

- The member is not taking concurrent muscle relaxants. ☐Yes ☐No*
  *If no, the prescriber attests to discussing the risks of using opioids and muscle relaxants concurrently, has provided documentation as to why concurrent use is necessary and has outlined a plan for tapering if appropriate. ☐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

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

  _____

  - 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 member needs to continue therapy or submit along with this form. _____

    _____

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**: _____