CAREFIRST
Opioids ER - Step Therapy with MME Limit and Post Limit

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 866-217-5644. Please contact CVS/Caremark at 844-449-8734 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Opioids ER - Step Therapy with MME Limit and Post Limit .

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (specify drug)

_____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through hospice or palliative care?	**Y** ☐	**N** ☐
2.	Is the requested drug being prescribed for CHRONIC pain severe and persistent enough to require an extended treatment period with a daily opioid analgesic in a patient who has been taking an opioid? [Chronic pain is generally defined as pain that typically lasts greater than 3 months.]	**Y** ☐	**N** ☐
3.	Can the patient safely take the requested dose based on their history of opioid use? [The lowest dosage necessary to achieve adequate analgesia should be prescribed.]	**Y** ☐	**N** ☐
4.	Has the patient been evaluated and will the patient be monitored regularly for the development of opioid use disorder?	**Y** ☐	**N** ☐
5.	Will the patient's pain be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety? [Because the risk of overdose increases as opioid doses increase, reserve titration to higher doses for patients in whom lower doses are insufficiently effective and in whom the expected benefits of using a higher dose opioid clearly outweigh the substantial risks.]	**Y** ☐	**N** ☐
6.	Is this request for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days?	**Y** ☐	**N** ☐
7.	Has the patient taken an immediate-release opioid for at least one week?	**Y** ☐	**N** ☐

8. Which drug is being requested? [Please check the drug being requested. These drugs should be prescribed only by healthcare professionals who are knowledgeable about the use of extended-release/long-acting opioids and how to mitigate the associated risks.]

- Belbuca (buprenorphine buccal film) (If checked, go to 13) ☐
- Butrans (buprenorphine transdermal system) (If checked, go to 14) ☐
- ConZip (tramadol hydrochloride extended-release capsules) (If checked, go to 15) ☐
- Fentanyl transdermal system (If checked, go to 16) ☐
- Hydrocodone bitartrate extended-release capsules (generic Zohydro ER) (If checked, go to 9) ☐
- Hydromorphone hydrochloride extended-release tablets (generic Exalgo) (If checked, go to 17) ☐
- Hysingla ER (hydrocodone bitartrate extended-release tablets) (If checked, go to 9) ☐
- Methadone 5 mg, 10 mg (methadone hydrochloride tablets) (If checked, go to 10) ☐
- Methadone 10 mg/mL Intensol soln (If checked, go to 10) ☐
- Methadone 5 mg/5 mL,10 mg/5 mL oral soln, 200 mg/20 mL injection (If checked, go to 10) ☐
- Morphine extended-release capsules (generic Avinza) (If checked, go to 12) ☐
- Morphine extended-release capsules (generic Kadian) (If checked, go to 18) ☐
- MS Contin (morphine extended-release tablets) (If checked, go to 19) ☐
- Nucynta ER (tapentadol extended-release tablets) (If checked, go to 20) ☐
- OxyContin (oxycodone hydrochloride extended-release tablets) (If checked, go to 22) ☐
- Oxymorphone hydrochloride extended-release tablets (generic Opana ER) (If checked, go to 21) ☐
- Tramadol hydrochloride extended-release (generic Ryzolt) (If checked, go to 15) ☐
- Tramadol hydrochloride extended-release (generic Ultram ER) (If checked, go to 15) ☐
- Xtampza ER (oxycodone extended-release capsules) (If checked, go to 23) ☐

9. Does the patient require use of MORE than the plan allowance of any of the following: A) 3 units per day of hydrocodone bitartrate ER capsules (generic Zohydro ER) 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, B) 2 units per day of Hysingla ER 20 mg, 30 mg, 40 mg, 60 mg, 80 mg, 100 mg OR hydrocodone bitartrate ER capsules (generic Zohydro ER) 50 mg, C) 1 unit per day of Hysingla ER 120 mg? **Y** ☐ **N** ☐

10. Is the requested methadone product being prescribed for detoxification treatment or as part of a maintenance treatment plan for opioid/substance abuse or addiction? **Y** ☐ **N** ☐

11. Does the patient require use of MORE than the plan allowance of any of the following: A) 4 tablets per day of Methadone 5 mg, B) 3 tablets per day of Methadone 10 mg, C) 20 mL per day of Methadone 5 mg/5 mL oral solution, D) 15 mL per day of Methadone 10 mg/5 mL oral solution, E) 3 mL per day of Methadone 10 mg/mL Intensol solution, F) 1.334 mL per day (i.e., 2 multidose vials per month) of Methadone 200 mg/20 mL injection? **Y** ☐ **N** ☐

12. Does the patient require use of MORE than the plan allowance of 2 capsules per day of morphine ER (generic Avinza) 30 mg, 45 mg, 60 mg, 75 mg, 90 mg OR MORE than the plan allowance of 1 capsule per day of morphine ER (generic Avinza) 120 mg? **Y** ☐ **N** ☐

13. Does the patient require use of MORE than the plan allowance of 3 films per day of Belbuca 75 mcg, 150 mcg, 300 mcg, 450 mcg OR MORE than the plan allowance of 2 films per day of Belbuca 600 mcg, 750 mcg, 900 mcg? **Y** ☐ **N** ☐

14. Does the patient require use of MORE than the plan allowance of 0.287 patch per day (i.e., 2 patches per week) of Butrans 5 mcg/hr, 7.5 mcg/hr, 10 mcg/hr OR MORE than the plan allowance of 0.144 patch per day (i.e., 1 patch per week) of Butrans 15 mcg/hr, 20 mcg/hr? **Y** ☐ **N** ☐

15. Does the patient require use of MORE than the plan allowance of 2 units per day of ConZip 100 mg, tramadol ER 100 mg (generic Ryzolt), or tramadol ER (generic Ultram ER) 100 mg, OR MORE than the plan allowance of 1 unit per day of ConZip 200 mg, 300 mg, or tramadol ER (generic Ryzolt) 200 mg, 300 mg, or tramadol ER (generic Ultram ER) 200 mg, 300 mg? **Y** ☐ **N** ☐

16. Does the patient require use of MORE than the plan allowance of 0.667 patch per day (i.e., 2 patches per 3 days) of fentanyl transdermal 12 mcg/hr, 25 mcg/hr, or 37.5 mcg/hr OR MORE than the plan allowance of 0.334 patch per day (i.e., 1 patch per 3 days) of fentanyl transdermal 50 mcg/hr, 62.5 mcg/hr, 75 mcg/hr, 87.5 mcg/hr, or 100 mcg/hr? **Y** ☐ **N** ☐

17. Does the patient require use of MORE than the plan allowance of 2 tablets per day of hydromorphone ER (generic Exalgo) 8 mg, 12 mg, 16 mg OR MORE than the plan allowance of 1 tablet per day of hydromorphone ER (generic Exalgo) 32 mg? **Y** ☐ **N** ☐

18. Does the patient require use of MORE than the plan allowance of 3 capsules per day of morphine ER (generic Kadian) 10 mg, 20 mg, 30 mg, 40 mg OR MORE than the plan allowance of 2 capsules per day of morphine ER (generic Kadian) 50 mg, 60 mg, 80 mg, 100 mg? **Y** ☐ **N** ☐

19. Does the patient require use of MORE than the plan allowance of any of the following: A) 4 tablets per day of MS Contin 15 mg, 30 mg, B) 3 tablets per day of MS Contin 60 mg, C) 2 tablets per day of MS Contin 100 mg, 200 mg? **Y** ☐ **N** ☐

20. Does the patient require use of MORE than the plan allowance of 3 tablets per day of Nucynta ER 50 mg, 100 mg, 150 mg OR MORE than the plan allowance of 2 tablets per day of Nucynta ER 200 mg, 250 mg? **Y** ☐ **N** ☐

21. Does the patient require use of MORE than the plan allowance of 3 tablets per day of oxymorphone ER (generic Opana ER) 5 mg, 7.5 mg, 10 mg, 15 mg, 20 mg, OR MORE than the plan allowance of 2 tablets per day of oxymorphone ER (generic Opana ER) 30 mg, 40 mg? **Y** ☐ **N** ☐

22. Does the patient require use of MORE than the plan allowance of 3 tablets per day of OxyContin 10 mg, 15 mg, 20 mg, 30 mg, 40 mg, OR MORE than the plan allowance of 2 tablets per day of OxyContin 60 mg, 80 mg? **Y** ☐ **N** ☐

23. Does the patient require use of MORE than the plan allowance of 3 capsules per day of Xtampza ER? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date