Neighborhood Health Plan OF RHODE ISLAND™

**Formulary Exception Request Form**
**Fax 1-866-423-0945**
**Pharmacy Dept. Phone 1-401-427-8200**

This form is to be used by participating physicians and providers to obtain coverage. Please complete the form by providing all of the following information. Fax the completed form to Neighborhood at **1-866-423-0945**. For real time Coverage Determination decisions, please go to Cover My Meds: https://www.covermymeds.com/epa/caremark/.

# Long Acting Opioid Prior Authorization Form

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|---|---|---|
| Enrollee's Name | | Date of Birth |
| Enrollee's Address | | |
| City | State | Zip Code |
| Phone | Enrollee's Member ID # | |
| Do you need this request decisioned within 24 hours? (72 hours is our normal turn-around-time) | | |

| **Prescriber's Information** | | |
|---|---|---|
| Name and NPI | | |
| Address | | |
| City | State | Zip Code |
| Office Phone | Fax | |
| Prescriber's Signature | | Date |

| **Diagnosis and Medical Information** | | |
|---|---|---|
| Medication: | Strength and Route of Administration: | Frequency: |
| New Prescription OR Date Therapy Initiated: | Expected Length of Therapy: | Quantity: |

| | | |
|---|---|---|
| Height/Weight: | Drug Allergies: | Diagnosis: |

| **CRITERIA Questions** | | | |
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| 1 | Is the requested drug being prescribed for pain associated with a cancer diagnosis, terminal condition, or pain being managed through hospice or palliative care? | Yes | No |

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| | [If yes, then no further questions, unless it is non formulary. If the answer to question 1 is yes and the medication is non-formulary, please proceed to question 15.] | | |
| 2 | Does the prescriber attest that Rhode Island's regulations for Pain Management, Opioid Use, and the Registration of Distributors of Controlled Substances are being followed? | Yes | No |
| 3 | Does the prescriber attest that they will use or are using an objective tool to monitor the member's pain? | Yes | No |
| 4 | Does the prescriber acknowledge that the risk of serious harm is markedly increased with concurrent use of benzodiazepines (BZD) and other Central Nervous System (CNS) depressants? | Yes | No |
| 5 | Does the prescriber attest that the patient has a prescription for OR is in possession of naloxone? | Yes | No |
| 6 | Does the prescriber attest that they have counseled the patient (or the patient's cohabitant(s), if available) on how to obtain and administer naloxone? | Yes | No |
| 7 | Does the prescriber attest to understanding the findings of the Centers for Disease Control and Prevention's (CDC's) Guideline for Prescribing Opioids for Chronic Pain (2016, 2017) which include: A) Long-term opioid therapy is associated with increased risk for serious harm including opioid use disorder, overdose, and death, B) Risk of harm increases with dosage, C) Opioids pose risk to all patients and currently available tools cannot rule out risk for opioid use disorder or other serious harm, D) Evidence for clinical benefit of long-term opioid therapy is insufficient? | Yes | No |
| 8 | Is this a request for continuation of therapy?<br>[If no, then skip to question 11.] | Yes | No |
| 9 | Has the original opioid dosing been titrated down from the initial authorization?<br>[If yes, then skip to question 12.] | Yes | No |
| 10 | In the prescriber's clinical opinion, is it inappropriate to decrease the dose for this patient?<br>[If yes, then skip to question 12.]<br>[If no, then no further questions.] | Yes | No |
| 11 | Is the requested drug being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid (i.e., not opioid naïve)? | Yes | No |
| 12 | Has the patient tried and failed ALL of the following alternatives for the treatment of pain: A) Non-pharmacologic therapy, B) Non-opioid therapy, C) Non-pharmacologic therapy and/or non-opioid therapy in combination with a | Yes | No |

| | | | |
|---|---|---|---|
| | low dose opioid? | | |
| 13 | Is the opioid being prescribed over the Food and Drug Administration (FDA) recommended dose or over 90 morphine milligram equivalents per day (MME/day)? | Yes | No |
| 14 | Does the prescriber attest to understanding the findings of the Centers for Disease Control and Prevention's (CDC's) Guideline for Prescribing Opioids for Chronic Pain (2016, 2017) which concluded that long term opioid therapy is associated with increased risk for serious harm (opioid use disorder, overdose, and death) in a dose dependent manner: A) Greater than or equal to 50 morphine milligram equivalents per day (MME/day) significantly increases the risk for harm and indicates need to reassess, B) Greater than or equal to 90 MME/day sharply increases risk for harm and requires justification of risk, C) Greater than or equal to 200 MME/day is associated with overdose (OD) death? | Yes | No |
| 15 | For non-formulary drug requests, has the patient tried and failed 3 formulary alternatives or has a medical reason why the formulary alternatives are not appropriate? | Yes | No |

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature_____ NPI_____ Date _____