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/.

Short-Acting Opioid Prior Authorization Form

(For daily doses of 90 milligrams morphine equivalents (MME) or greater)

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			
1	Is the requested drug being prescribed for pain associated with a cancer	Yes	No

	diagnosis, terminal condition, or pain being managed through hospice or palliative care? [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 14.]		
2	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
3	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
4	Does the prescriber attest that the patient has a prescription for OR is in possession of naloxone?	Yes	No
5	Does the prescriber attest that they have counseled the patient (and the patient's cohabitant(s), if available) on how to obtain and administer naloxone?	Yes	No
6	Is the patient opioid naïve? [If no, then skip to question 10.]	Yes	No
7	Has the patient tried and failed non-pharmacologic therapy and non-opioid therapy to treat their pain?	Yes	No
8	Is this request for greater than 30 morphine milligram equivalents per day (MME/day)? [Note: The State of Rhode Island Opioid Prescribing Laws state that opioid naïve patients shall not exceed 30 MME/day.]	Yes	No
9	Is this request for greater than 20 tablets? [Note: The State of Rhode Island Opioid Prescribing Laws state that opioid naïve patients shall not exceed a maximum total of 20 tablets.]	Yes	No
10	Has the patient tried and failed non-pharmacologic therapy and/or non-opioid therapy in combination with a LOW DOSE opioid?	Yes	No
11	Is this a request for continuation of therapy? [If yes, go to Question 12.]	Yes	No
12	Has the original opioid dosing been titrated down from the initial authorization?	Yes	No

	[If yes, then no further questions unless the medication is non formulary. If the medication is non-formulary proceed to question 14.]		
13	In the prescriber's clinical opinion, is it inappropriate to decrease the dose for this patient?	Yes	No
14	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 _____