Select Health of South Carolina

Healthy Connections

Long-Acting Opioid Request Form

Is this request for medication prescribed for treatment of pain related to cancer, palliative care, or end-of-life care?
☐ Yes ☐ No (If yes, approve for six months. If no, approve for a one-month duration; must submit each month for three months, then subsequent approvals will be in three-month intervals.)

Member name:	Member ID #:	Member date of birth:
Medication allergies:	Member weight (kg):	Member height (ft/in):
Prescriber name:	Prescriber specialty:	Medicaid provider ID # or NPI#:
Prescriber address:		
Prescriber phone number:	Office fax number:	Office contact:
This request is for: ☐ A long-acting opioid and patient has had previous history of short-acting opioids.		
Please explain medical necessity in detail:		

Drug information (one drug per request form)	
Drug name/dosage form	Strength
Directions	Quantity requested
Request is for: ☐ Initiation of therapy ☐ Continuation of therapy	
For continuation of therapy, is the dose currently being tapered? ☐ Yes ☐ No	
If no, please explain:	

Treatment information	
This medication is being used for: ☐ acute condition ☐ chronic condition **(check one only)**	
Is this medication being used for postoperative pain? ☐ Yes ☐ No If yes, date of surgery:	

Diagnoses for which the opioid is prescribed (include primary and secondary diagnoses applicable to this request): (ICD code and description)	
Diagnosis	Date of diagnosis
Diagnosis	Date of diagnosis
List other **nonopioid treatments** that have been **tried** for this condition, both pharmacological and nonpharmacological:	

Pharmacological treatments (including preferred and nonpreferred medications)

Drug / Strength	Long-acting or short-acting (if applicable)	Directions	Start date/end date	Reason for discontinuation (if applicable)

Nonpharmacological treatments

Treatment	Start date/end date

Prescriber attestation

Please indicate **Yes/True** or **No/False** for each of the following attestations. Explanation is required for each **No/False** answer in order for the request to be considered for approval.

LONG - ACTING OPIOIDS

Yes (True)	No (False)	The prescriber attests to the following:
☐	☐	1. The **scripts program** will be accessed **each** time a controlled prescription is written for this patient.
☐	☐	2. Diagnosis is chronic pain and patient previously utilized short-acting opioids for this condition for at least three months without adequate pain relief and now requires around-the-clock pain management.
☐	☐	3. A Pain Treatment Plan and goals (updated upon reauthorization) consistent with the SC LLR Joint Revised Pain Management Guidelines is provided.
☐	☐	4. Patient is currently using or has been prescribed a separate nonopioid medication for baseline pain relief **or** a medical reason is given why nonopioid therapy cannot be used. Nonopioid medication can include, but is not limited to: i. Antidepressants: Amitriptyline, Nortriptyline, Duloxetine, Venlafaxine, Savella ii. Anticonvulsants: Gabapentin capsules, Carbamazepine iii. Muscle relaxants: Baclofen, Cyclobenzaprine, Methocarbamol, Tizanidine tablets iv. NSAIDs: Aspirin, Celebrex (ST required), Diclofenac, Etodolac, Ibuprofen, Indomethacin, Meloxicam, Nabumetone, Naproxen, Salsalate, Sulindac v. Nonopioid analgesics: Acetaminophen
☐	☐	5. Dose prescribed is based on use of a functional pain scale with comparison to baseline and/or previous functional pain scale. Functional pain scale must be included in documentation.
☐	☐	6. Prescriber has attested to the following: a. An Opioid Treatment Agreement signed by both the patient and prescriber is on file. b. Checking the SCRIPTS monitoring program for each request. c. Benefits and potential harms of opioid use have been discussed with this patient. In addition, risks of combining opioids with other central nervous system depressants such as benzodiazepines, alcohol, other sedatives, skeletal muscle relaxants, illicit drugs such as heroin, or other opioids has been discussed with this patient. d. If patient has a high-risk condition stated in the Centers for Disease Control and Prevention Guidelines (e.g., 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) prescriber attests to discussing heightened risks of opioid use and has educated patient on naloxone use and has considered prescribing naloxone.
☐	☐	7. For nonformulary opioid products, patient must meet criteria 1 – 6 **and** try and fail two formulary long-acting opioid drugs.
☐	☐	8. **For reauthorizations only**: A treatment plan that includes current and previous goals of therapy for both pain and function has been developed for this patient.

If you have indicated **No/False** to any of the above attestations, please explain in detail:

Prescriber signature	Date