Select Health of South Carolina

Healthy Connections

Short-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-month duration.)

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: ☐ Exceeding 90MME ☐ Exceeding one prescription per month ☐ Exceeding five-day supply ☐ Other		
If you have selected a request listed above, 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	
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 for the request to be considered for approval.

	Yes (True)	No (False)	The prescriber attests to the following:
SHORT - ACTING OPIOIDS	☐	☐	A. The **scripts program** will be accessed **each** time a controlled prescription is written for this patient.
	☐	☐	B. Diagnosis is for pain uncontrolled by nonopioid medications.
	☐	☐	C. Has documentation been provided supporting medical necessity?
	☐	☐	D. Benefits and potential harms of opioid use have been discussed with this patient. In addition, if the patient has concurrent comorbidities or is taking medications that could potentially cause drug-drug interactions, an assessment of increased risk for respiratory depression has been completed and discussed with the patient. The risk of combining opioids with other central nervous system depressants, such as benzodiazepines, alcohol, or illicit drugs such as heroin, has also been specifically addressed.
	☐	☐	E. 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.
	☐	☐	F. **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