Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ____

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ________________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Horizon NJ Health

Morphine Sulfate Extended Release – Medical Necessity Request

*****Please complete page 1 for New/Initial requests*****

1. Please indicate if the member has any of the following contraindications for the requested drug:

MS Contin	Kadian
□ Significant respiratory depression □ Acute or severe bronchial asthma in an unmonitored setting or in absence of resuscitative equipment. □ Has or is suspected of having paralytic ileus □ Concurrent use of monoamine oxidase inhibitors (MAOIs) or use of MAOIs within the last 14 days □ NONE	□ Significant respiratory depression □ Acute or severe bronchial asthma in an unmonitored setting or in absence of resuscitative equipment. □ Has or is suspected of having paralytic ileus □ NONE

2. What is the diagnosis?

□ Pain

- What is the severity of the pain? □ Mild □ Moderate □ Severe

□ Other: ____

3. Is the pain chronic? **Yes** or **No**

4. Is the member's pain severe enough to require daily around-the-clock, long-term opioid treatment? **Yes or No**

5. Can member try an alternative treatment (such as non-opioid analgesics or immediate-release opioids)? **Yes or No**

- If Yes, Please call the medication prescription to the member's pharmacy

- If No, Please provide clinical reason why not____

6. Will the member be taking any other strengths of extended-release morphine sulfate concurrently with this strength? **Yes or No**

- If Yes, list the other strength and dosing directions of extended-release morphine sulfate that the member will be receiving.

____

7. Is the member on any other long-acting opioid pain controller? (i.e. OxyContin, Avinza, MS Contin, Kadian, Oramorph, Duragesic/Fentanyl, or Butrans) **Yes or No**

- If Yes, Which long-acting opioid pain controller(s) is the member receiving? __________________________
- What is the clinical reason why the member is receiving more than one long-acting opioid pain controller?

____

8. Please document any long-acting opioids that have recently been discontinued or will be discontinued if extended-release morphine sulfate is approved (include date drug was discontinued)?

____

Physician office's signature*_________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: ______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

*****Complete page 2 only for Subsequent/Renewal requests*****

1. What was the previous dose? ____

2. Will the previous dose be discontinued?
   - □ **Yes**
   - □ **No - will be taking in addition to new dose**
   - □ **No - Same as previous dose**

3. What is the new, total dose of extended-release morphine sulfate that the member will be receiving (include any other strengths of extended-release morphine sulfate that the member will also be receiving)? ________________________

   ____

4. Is the member on any other long-acting opioid pain controller? (i.e. OxyContin, Avinza, MS Contin, Kadian, Oramorph, Duragesic/Fentanyl, or Butrans) **Yes or No**

   - If Yes, Which long-acting opioid pain controller(s) is the member receiving? ______________

   - What is the clinical reason why the member is receiving more than one long-acting opioid pain controller? ____

5. Has the member experienced improvement in pain and function? **Yes or No**
   If No, please provide documentation outlining prescriber's plan (e.g., taper medication with intention to discontinue treatment, change in drug therapy or dose, maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate, and/or consult a pain management specialist)

Physician office's signature*_________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**