Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Oxycodone Controlled-Release (OxyContin) – Medical Necessity Request

Please complete page 1 for New/Initial requests*

1. Please indicate if the member has any of the following contraindications:
   - □ 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
     - Is the member's pain acute or chronic? □ Acute □Chronic
   - □ Other: _____

3. Does the member require daily, around the clock, long-term opioid treatment?
   - □ Yes □ No

4. Can member try an alternative treatments (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_____

5. Is the member opioid naive? (i.e. never used opioid analgesics in the recent past?) [NOTE: Examples of opioids are OxyContin, Avinza, MS Contin, Kadian, Oramorph, Duragesic/Fentanyl, Opana, Percocet, or Vicodin] **Yes or No**
   - If Yes, is the dose for 10 mg every 12 hours? **Yes or No**
     - If No (the dose is not for 10 mg -every 12 hours), would the physician consider changing the dose to 10mg - every 12 hours? **Yes or No**
       - If No, please provide the clinical reason why the dose cannot be changed to 10mg every 12 hours for a member who is opioid naïve:

         _____

6. What opioid therapy is the member currently receiving and when was it last received? (include dose, directions and fill dates)

_____

7. Will the member be taking any other strengths of Oxycontin concurrently with this strength? **Yes or No**
   - If Yes, list the other strength and dosing directions of OxyContin that the member will be receiving.

   _____

8. 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?

   _____

9. Please document any long-acting opioids that have recently been discontinued or will be discontinued if Oxycontin 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 OxyContin that the member will be receiving (include any other strengths of OxyContin 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 symptomatic improvement in pain and function?
   □ Yes
   □ No
   -If No, please provide documentation outlining the 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**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**