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

Drug Name: _____ Strength: _____ Directions: _____

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

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

Horizon NJ Health

Opioids – Medical Necessity Request

*****Complete pages 1-3 for Initial Requests Only*****

Contraindication Information (Please indicate if the member has any of the following contraindications for the requested drug):

Abstral, Lazanda, Subsys
□ Patients who are not opioid tolerant □ Acute or postoperative pain including headache/migraines and dental pain, or acute pain in the emergency department □ Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment □ Known or suspected gastrointestinal obstruction, including paralytic ileus □ NONE
Actiq, Fentora
□ Patients who are not opioid tolerant □ Significant respiratory depression □ Acute or postoperative pain including headache/migraines and dental pain, or acute pain in the emergency department □ Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment □ Known or suspected gastrointestinal obstruction, including paralytic ileus □ NONE
Arymo ER, Conzip, Embeda, Kadian, MorphaBond ER, MS Contin, Ryzolt ER, Ultram ER
□ Significant respiratory depression □ Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment □ Concurrent use of monoamine oxidase inhibitors (MAOIs) or use of MAOIs within the last 14 days □ Known or suspected gastrointestinal obstruction, including paralytic ileus □ NONE
Avinza
□ Significant respiratory depression □ Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment □ Known or suspected paralytic ileus □ NONE
Belbuca, Butrans, Hysingla ER, Methadone, Oxycontin, Xtampza ER, Zohydro ER
□ Significant respiratory depression □ Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment □ Known or suspected gastrointestinal obstruction, including paralytic ileus □ NONE
Duragesic
□ Patients who are not opioid-tolerant □ Management of acute or intermittent pain or in patients who require opioid analgesia for a short period of time □ Management of post-operative pain, including use after out-patient or day surgeries □ Management of mild pain □ Significant respiratory depression □ Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment □ Known or suspected gastrointestinal obstruction, including paralytic ileus □ NONE

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: _____

Exalgo
□ Patients who are not opioid tolerant □ Significant respiratory depression □ Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment □ Known or suspected gastrointestinal obstruction, including paralytic ileus □ Patients who have had surgical procedures and/or underlying disease resulting in narrowing of the gastrointestinal tract or have "blind loops" of the gastrointestinal tract or gastrointestinal obstruction □ NONE
Nucynta ER
□ Significant respiratory depression □ Acute or severe bronchial asthma or hypercarbia in an unmonitored setting or in the absence of resuscitative equipment □ Known or suspected gastrointestinal obstruction, including paralytic ileus □ Concurrent use of monoamine oxidase inhibitors (MAOIs) or use of MAOIs within the last 14 days □ NONE
Opana ER
□ Significant respiratory depression □ Acute or severe bronchial asthma in an unmonitored setting or in the absence of resuscitative equipment □ Known or suspected gastrointestinal obstruction, including paralytic ileus □ Moderate or severe hepatic impairment □ NONE

Diagnosis Information (please indicate the diagnosis and answer the related questions):

1. What is the diagnosis?
   - □ Pain
     - Is the pain chronic? **Yes** or **No**
     - Is the pain severe enough to require daily around-the-clock long-term opioid treatment? **Yes** or **No**
   - □ Breakthrough pain related to underlying persistent cancer pain
   - □ Other: _____

General Questions (please answer the following questions)**:**

2. Is the member currently taking buprenorphine or buprenorphine/naloxone for the treatment of opioid dependence? **Yes or No**
   - If **yes**, what is the reason the member will be taking buprenorphine or buprenorphine/naloxone concurrently with opioid therapy? _____

3. Can the member try an alternative treatment (such as non-opioid analgesics or immediate-release opioids)? **Yes** or **No**
   - If **yes**, please call the alternative medication prescription to the member's pharmacy
   - If **no**, please provide the clinical reason as to why below:
     - □ Member is receiving active cancer treatment, palliative care, or end-of-life care
     - □ Has tried the following alternatives (please provide reason for discontinuation):_____
       _____
     - □ Other: _____

4. Is the member already receiving opioid therapy? (NOTE: Examples of opioids include OxyContin, Percocet, etc.) **Yes** or **No**
   - If **yes,** what opioid therapy is the member currently receiving and when was it last received? (include dose, directions and fill dates) _____

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: _____

Additional Questions (please answer all corresponding questions for the requested drug):

Abstral, Actiq, Fentora, Lazanda, Subsys

a. Is the member currently receiving around-the-clock opioid therapy for underlying persistent cancer pain? **Yes** or **No**
   - If **yes,** please provided the name, dose, directions of the opioids the member is receiving and the date last received:
     _____
     _____

b. Will the member continue around-the-clock opioids? **Yes** or **No**

c. Will the member be managed by an oncologist or pain specialist? **Yes** or **No**

Arymo ER, Avinza, Belbuca, Butrans, Conzip, Embeda, Exalgo, Hysingla ER, Kadian, Morphabond ER, MS Contin, Nucynta ER, Opana ER, OxyContin, Ryzolt ER, Ultram ER, Xtampza ER, Zohydro ER

a. Is the member currently on or will the member be on any other long-acting opioid pain controller(s)? (i.e. Oxycontin, Avinza, MS Contin, Kadian, Duragesic, or Butrans) **Yes** or **No**
   - If **yes,** which long-acting opioid pain controller(s) will the member be receiving concurrently?_____
     _____
   - What is the clinical reason why the member is receiving more than one long-acting opioid pain controller?
     _____
   - Please document any long-acting opioids that have been recently discontinued or will be discontinued if the requested medication is approved:_____

Duragesic

a. Is the member currently on or will the member be on any other long-acting opioid pain controller(s)? (i.e. Oxycontin, Avinza, MS Contin, Kadian, Duragesic, or Butrans) **Yes** or **No**
   - If **yes,** which long-acting opioid pain controller(s) will the member be receiving concurrently?_____
     _____
   - What is the clinical reason why the member is receiving more than one long-acting opioid pain controller?
     _____
   - Please document any long-acting opioids that have been recently discontinued or will be discontinued if the requested medication is approved:_____

b. How often will the Duragesic patch be applied?
   - ☐ **Every 72 hours**
   - ☐ **Every 48 hours**
     - Has the member tried an every 72-hours regimen? **Yes** or **No**

       If **yes:** Was adequate pain control achieved using a 72-hour regimen at the requested strength? **Yes** or **No**

       ☐ If **yes**, please provide the clinical reason for requesting an every 48 hour regimen if adequate pain control was achieved using an every 72 hour regimen: _____
       _____

       If **no:** Please provide the clinical reason why the member cannot try an every 72-hour regimen:_____
       _____

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 pages 4-5 only for Subsequent/Renewal requests****

1. What is the diagnosis?
   - ☐ Pain
     - Is the pain chronic? **Yes** or **No**
     - Is the pain severe enough to require daily around-the-clock long-term opioid treatment? **Yes** or **No**
   - ☐ Breakthrough pain related to underlying persistent cancer pain
     - Is the member already receiving and is tolerant to around-the-clock opioid therapy? **Yes** or **No**
   - ☐ Other:_____
2. Is the member currently taking buprenorphine or buprenorphine/naloxone for the treatment of opioid dependence? **Yes or No**
   a. If **yes**, what is the reason the member will be taking buprenorphine or buprenorphine/naloxone concurrently with opioid therapy? _____
      _____
3. The request is for a:
   - ☐ Dose increase
     - What additional opioid medication(s) is the member currently taking that necessitates the dose increase? Include drug name, strength, directions, and date of last fill. (NOTE: Examples of opioids are Opana, Percocet, Dilaudid, etc.)
       _____
       _____
     - How long was the member on the previous dose? _____
   - ☐ Dose decrease
   - ☐ Dose remaining the same
4. Will the previous dose be discontinued? **Yes** or **No**

Additional Questions (Please answer all corresponding questions for requested drug):

Abstral, Actiq, Fentora, Lazanda, Subsys

a. Will the member continue around-the-clock opioids? **Yes** or **No**
b. Will the member be managed by an oncologist or pain specialist? **Yes** or **No**

Arymo ER, Avinza, Belbuca, Butrans, Conzip, Embeda, Exalgo, Hysingla ER, Kadian, Morphabond ER, MS Contin, Nucynta ER, Opana ER, OxyContin, Ryzolt ER, Ultram ER, Xtampza ER, Zohydro ER

a. Is the member currently on or will the member be on any other long-acting opioid pain controller(s)? (i.e. Oxycontin, Avinza, MS Contin, Kadian, Duragesic, or Butrans) **Yes** or **No**
   - If **yes,** which long-acting opioid pain controller(s) will the member be receiving concurrently?_____
     _____
   - What is the clinical reason why the member is receiving more than one long-acting opioid pain controller?
     _____
b. Has the member experienced an improvement in pain and function? **Yes** or **No**
   - If **no,** please provide the prescriber's plan to improve the member's pain and function (e.g., taper medication with intention to discontinue, change in drug therapy or dose, maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate, and/or consult a pain management specialist) _____
     _____

Duragesic

a. Is the member currently on or will the member be on any other long-acting opioid pain controller(s)? (i.e. Oxycontin, Avinza, MS Contin, Kadian, Duragesic, or Butrans) **Yes** or **No**
   - If **yes,** which long-acting opioid pain controller(s) will the member be receiving concurrently?_____

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: _____

_____

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

_____

b. How often will the Duragesic patch be applied?

- ☐ **Every 72 hours**
- ☐ **Every 48 hours**
  - Has the member tried an every 72-hours regimen? **Yes** or **No**
    - If **yes:** Was adequate pain control achieved on a 72-hour regimen at the requested strength? **Yes** or **No**
      - ☐ If **yes**, please provide the clinical reason for requesting an every 48 hour regimen if adequate pain control was achieved using an every 72 hour regimen: _____

_____

    - If **no:** Please provide the clinical reason why the member cannot try an every 72-hour regimen:_____

_____

c. Has the member experienced an improvement in pain and function? **Yes** or **No**

- If **no,** please provide the prescriber's plan to improve the member's pain and function (e.g., taper medication with intention to discontinue, change in drug therapy or dose, maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate, and/or consult a pain management specialist) _____

_____

_____

Methadone

a. What is the diagnosis?

- ☐ Chronic pain:
  - Is the pain severe enough to require daily around-the-clock long-term opioid treatment? **Yes** or **No**
  - Has the member experienced an improvement in pain and function? **Yes** or **No**

    If **no,** please provide the prescriber's plan to improve the member's pain and function (e.g., taper medication with intention to discontinue, change in drug therapy or dose, maximize pain treatment with nonpharmacologic and nonopioid pharmacologic treatments as appropriate, and/or consult a pain management specialist) _____

_____

_____
- ☐ Opioid withdrawal/Opioid Dependence
- ☐ Other:_____

Physician office's signature*_____ Print Name_____

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