First CarolinaCare INSURANCE COMPANY

Morphine Equivalent Dose (MED)/Opioid Medication Supplemental Information Form

Effective January 1, 2021

You can complete this form and fax it to (217) 902-9798, or fill out only Section D of this form and attach it as additional documentation to the Pharmacy Preauthorization Request Form when you request preauthorization through the pharmacy provider portal. If you have questions, call (800) 574-8556.

Section A—Member Information

Today's Date:	First Name:	Last Name:
Member ID #:	Date of Birth:	
Primary Insurance:		

Is the requested medication **new** ☐ or **a continuation of therapy** ☐? If so, what is the start date? _____
Is this patient currently hospitalized? ☐ **Yes** ☐ **No**

Section B—Provider Information

First Name:	Last Name:		
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI:	
Specialty:	Email:	Office Contact Name:	

Section C—Clinical Information

Include all opioid drugs the member is currently using.

Drug Name	Strength	Quantity	Days Supply	Directions for Use

Diagnosis (Please provide specific details.):	ICD-10 code(s):

☐ Request is not urgent ☐ Request is urgent
☐ I certify that the information provided is true and accurate to the best of my knowledge.

Prescriber's Signature _____ Date _____

Section D—Treatment Details *Please read carefully and complete ALL fields that apply.*

Refer to this document for MED conversion factors. Supporting chart documentation is required.

1. Cancer treatment, sickle cell disease and hospice.

Is member receiving opioid due to cancer treatment? ☐ **Yes** ☐ **No** **If yes, please complete the following:**
Cancer type: _____ Date of diagnosis: _____

Is member receiving opioid due to sickle cell disease? ☐ **Yes** ☐ **No** **If yes, please complete the following:**
Date of diagnosis:_____

Is member receiving hospice services? ☐ **Yes** ☐ **No**

Approval is for 12 months.
Note: Completion of remaining sections is NOT required if treating cancer, sickle cell disease or hospice-enrolled patients.

2. All opioid claims unrelated to cancer, sickle cell disease or hospice care.*† (This section is required for all requests)

Has member used opioid medications in the previous 120 days? ☐ **Yes** ☐ **No**
If Yes, list drug names, doses, and dates of use _____
If No, please submit documentation of medical necessity for an opioid naive patient to receive opioid therapy for greater than 7 days.

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Is member using a benzodiazepine concurrently with opioid treatment? ☐ **Yes** ☐ **No**

If Yes, list drug name, dose, and dates of use _____

If Yes, has provider reviewed this contraindication and determined that concurrent use of an opioid is needed even with the associated risk? ☐ **Yes** ☐ **No**

Has member been educated on the availability and proper use of immediate opioid antagonist therapy (Narcan)? ☐ **Yes** ☐ **No**

Has provider seen member in the last 3 months? ☐ **Yes** ☐ **No**

Date of last visit_____

Has provider done a full evaluation of member's pain and identified any potential underlying causes? ☐ **Yes** ☐ **No**

Has provider evaluated non-pharmacological therapies? ☐ **Yes** ☐ **No**

Please list_____

Has member been escalated to the requested dose? ☐ **Yes** ☐ **No**

Has provider discussed the risks of opioid treatment with member? ☐ **Yes** ☐ **No**

3. Opioid therapies with a total daily morphine equivalence dose (MED) of 100mg or more, unrelated to cancer, sickle cell disease or hospice care.*†

Does provider have a pain contract with member restricting the prescribing of pain medication to no more than 2 providers? ☐ **Yes** ☐ **No**

If applicable, list other provider(s)_____

Does provider order a urine toxicology screen for member at least annually? ☐ **Yes** ☐ **No** **Please attach most recent test results.**

Has provider reviewed member's state prescription monitoring program at least once in the last 3 months? ☐ **Yes** ☐ **No**

In addition to the above, provide a treatment plan including the long-term goals of treatment as well as a tapering plan for member to discontinue pain medication or achieve pain control at a level below 100mg MED. If no tapering plan exists, indicate why_____

If the opioid drug will treat post-operative pain, is there a plan to taper pain medications? ☐ **Yes** ☐ **No**

4. Long-acting opioids for new starts to therapy, unrelated to cancer, sickle cell or hospice care.*†

Does provider have a pain contract with member restricting the prescribing of pain medication to no more than 2 providers? ☐ **Yes** ☐ **No**

If applicable, list other provider(s)_____

Does provider order a urine toxicology screen for member at least annually? ☐ **Yes** ☐ **No** **Please attach most recent test results.**

Has provider reviewed member's state prescription monitoring program at least once in the last 3 months? ☐ **Yes** ☐ **No**

Has member been on an equivalent of at least 60mg of morphine per day for at least one week? ☐ **Yes** ☐ **No**

Does the member have a documented diagnosis of pain severe enough to require daily, around-the-clock long-term opioid treatment? ☐ **Yes** ☐ **No**

If the long-acting drug will treat post-operative pain, is there a plan to taper pain medications? ☐ **Yes** ☐ **No**

Attention: Long-acting opioid medications are not recommended for treating post-operative pain. Non-opioid analgesics and immediate-release opioids are recommended for short-term use.

5. Tramadol extended-release (generic Ultram ER) unrelated to cancer, sickle cell disease or hospice care.*†

Does the member have a history of failure, contraindication, or intolerance to a 30 day trial of tramadol immediate-release (IR)? ☐ **Yes** ☐ **No**

Document dose, duration, and date of trial_____

6. Nucynta Immediate-Release (IR) unrelated to cancer, sickle cell disease or hospice care.*†

Does member have a history of failure, contraindication, or intolerance to a 30 day trial of tramadol IR or a Tier 1 short-acting opioid (including but not limited to hydrocodone, oxycodone, and morphine)? ☐ **Yes** ☐ **No**

Document drug(s), dose, duration and date of trial_____

***Approval for chronic pain treatment unrelated to cancer, sickle cell disease, or hospice care: 6 months at current calculated MED at time of request.**

†Approval for short-term post-operative pain treatment: 1 month at calculated MED level.