Ohio Opioids

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Abstral
☐ Actiq
☐ Arymo ER
☐ ConZip
☐ Fentora
☐ Exalgo (brand name)
☐ Kadian (brand name)
☐ Lazanda
☐ levorphanol, used on as needed basis for pain (IR)
☐ levorphanol, used as long-term, around-the-clock treatment for pain (ER)
☐ MS Contin (brand name)
☐ Nucynta ER
☐ Opana ER (brand name)
☐ Oxycontin
☐ Roxicodone (brand name)
☐ Subsys
☐ Zohyrdo ER
☐ any other opioid: _____

Strength: ICD10:
Dosing instructions:
Quantity per month requested:
Expected duration:

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Clinical Information:

Is the prescriber aware of the risk of increased opioid toxicity with the concurrent use of a benzodiazepine? ☐ Yes ☐ No
Can the prescribing physician attest that the continued use of this combination therapy is clinically necessary for this patient? ☐ Yes ☐ No

Which of the following applies to your patient?
☐ patient is in a hospice care program
☐ patient has a diagnosis of a terminal condition *
☐ patient has cancer
☐ patient has a condition associated with cancer or history of cancer
☐ none of the above **

*(if terminal condition) Is your patient in a hospice care program? ☐ Yes ☐ No
**(if none of the above) Does your patient have chronic pain without a cancer diagnosis? ☐ Yes ☐ No

If chronic pain without cancer:
Have non-opioid therapies been optimized and are being used in conjunction with opioid therapy according to the prescribing physician? Non-opioid therapies include: non-opioid medications (for example: nonsteroidal anti-inflammatory drugs [NSAIDs], tricyclic antidepressants, serotonin and norepinephrine reuptake inhibitors [SNRIs], anticonvulsants), exercise therapy, weight loss, cognitive behavioral therapy. ☐ Yes ☐ No

Is your patient also taking a benzodiazepine while using an opioid? (benzodiazepines include: alprazolam, Ativan, chlordiazepoxide, clobazam, clonazepam, clorazepate, diazepam, estazolam, flurazepam, Halcion, Klonopin, Librax, lorazepam, midazolam, Onfi, oxazepam, Restoril, Sympazan, temazepam, Tranxene, triazolam, Valium, Xanax) ☐ Yes ☐ No

Does your patient's opioid dose exceed 80 MME (morphine milligram equivalent)? ☐ Yes ☐ No
(if >80MME) Can the prescribing physician attest that this dose is the lowest effective or appropriate dose for this patient? ☐ Yes ☐ No

Has the prescribing physician re-established informed consent with the patient AND provided written information on the potential adverse effects of long-term opioid therapy? ☐ Yes ☐ No
Can the prescribing physician attest that the patient's functional status (including activities of daily living, adverse effects, analgesia, and aberrant behavior) have been reviewed and documented? ☐ Yes ☐ No
Has the prescribing physician reviewed the patient's progress toward treatment objectives for the duration of treatment? ☐ Yes ☐ No
Has the prescribing physician checked the patient's history of controlled substance prescriptions using the Ohio Automated Rx Reporting System (OARRS) state prescription drug monitoring program? ☐ Yes ☐ No
Has the prescribing physician evaluated the use of a patient pain treatment agreement? ☐ Yes ☐ No
Has the prescribing physician considered an evaluation of the patient by one or more other providers who specialize in the treatment of the area, system, or organ of the body perceived as the source of the pain? ☐ Yes ☐ No

Which of the following alternatives has your patient tried?

☐ fentanyl lozenges (generic Actiq)
☐ hydromorphone (generic Dilaudid)
☐ hydrocodone/acetaminophen (generic Lorcet, Norco, Vicodin, Xodol)
☐ Hysingla ER
☐ Morphabond ER
☐ morphine (generic MSIR)
☐ oxycodone (generic OxyIR, Roxicodone)
☐ oxycodone/acetaminophen (generic Percocet)
☐ oxymorphone (generic Opana)
☐ Subsys
☐ tramadol 50 mg tablets (generic Ultram)
☐ tramadol 100 mg, 200 mg or 300 mg extended release (ER) tablets (generic Ryzolt)
☐ tramadol 100 mg, 200 mg or 300 mg extended release (ER) capsules (generic ConZip)
☐ Xtampza ER

For each alternative above that the patient has tried, please provide the following details: drug name, date(s) taken and for how long, and what the documented results were of taking each drug, including any documented intolerances or adverse reactions your patient experienced.

If requesting Actiq:
Is this medication being used for management of breakthrough cancer pain? ☐ Yes ☐ No
(if yes) What is the cancer diagnosis? _____
(if no) What is the diagnosis related to use? _____
Per the information given above, did your patient have documented inadequate response or intolerance to Subsys? ☐ Yes ☐ No (see last question)

If requesting Abstral, Fentora, Lazanda:
Is this medication being used for management of breakthrough cancer pain? ☐ Yes ☐ No
(if yes) What is the cancer diagnosis? _____
(if no) What is the diagnosis related to use? _____
Per the information given above, did your patient have documented inadequate response or intolerance to generic fentanyl lozenge? ☐ Yes ☐ No (see last question)
Per the information given above, did your patient have documented inadequate response or intolerance to Subsys? ☐ Yes ☐ No (see last question)

If requesting ConZip:
Per the information given above, did your patient have a documented intolerance to tramadol 100 mg, 200 mg or 300 mg ER CAPSULES (generic ConZip)? ☐ Yes ☐ No (see last question)
Per the information given above, did your patient have a documented intolerance to tramadol 50 mg tablets (generic Ultram)? ☐ Yes ☐ No (see last question)
Per the information given above, did your patient have a documented intolerance to tramadol 100 mg, 200 mg or 300 mg ER TABLETS (generic Ryzolt)? ☐ Yes ☐ No (see last question)

If requesting levorphanol as ER or any of the following: Arymo ER, Exalgo, Kadian, MS Contin, Nucynta ER, Opana ER, Oxycontin, Zohydro ER
Per the information given above, did your patient have documented failure or intolerance to any of the following: Hysingla ER, Morphabond ER, Xtampza ER?

☐ Yes, to ALL 3 of these
☐ Yes, to only 1 or 2 of these (see last question)
☐ No, none of these (see last question)

If requesting levorphanol as IR or Roxicodone:
Per the information given above, did your patient have documented intolerance to any of the following drugs checked as tried? (see last question)
☐ hydromorphone (generic Dilaudid)
☐ hydrocodone/acetaminophen (generic Lorcet, Norco, Vicodin, Xodol)
☐ morphine (generic MSIR)
☐ oxycodone (generic OxyIR, Roxicodone)
☐ oxycodone/acetaminophen (generic Percocet)
☐ oxymorphone (generic Opana)

If requesting Subsys:
Is this medication being used for management of breakthrough cancer pain? ☐ Yes ☐ No
(if yes) What is the cancer diagnosis? _____
(if no) What is the diagnosis related to use? _____
Per the information given above, did your patient have documented inadequate response or intolerance to generic fentanyl lozenge?
☐ Yes ☐ No (see last question)

For the listed alternatives in the above questions that were NOT tried:
Is your patient able to try those drugs? ☐ Yes ☐ No
(if no) Please list all documented inability or contraindication per FDA label that your patient has to using each of those alternatives, including any reasons your patient is not a candidate to use those alternatives.

Additional pertinent information: (*please include other clinical reasons for drug, relevant lab values, etc.)*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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