Health New England

Medication Request Form (MRF)
Short-Acting Opioids, Long-Acting Opioids & Opioid Cough Medications

Instructions:
This form is also to be used by participating physicians and pharmacy providers to obtain coverage of **Short-Acting Opioids, Long-Acting Opioids & Opioid Cough Medications.** Please complete this form and fax to Optum at **(800) 550-9246**. If you have any questions regarding this process, please contact Optum clinical call center at **(800) 918-7545.**

Patient Information (all required)	Physician Information (all required)
Patient Name:	**Physician Name:** **Specialty:**
Patient Health New England ID#:	**Health New England Provider #:**
Patient Date of Birth:	**NPI #:**
Allergies:	**Telephone #: ( ) -**
Diagnosis:	**Fax #: ( ) -**

Drug Information

Requested Drug/Strength/Form:

Dosage Strength and Form (be specific):	**Quantity (per month):**	**Refills:**

Physician Signature: **Date:**

Documentation of Medical Necessity:

☐ **Initial Request for Short-Acting Opioids**

- ☐ The patient has diagnosis of cancer or end of life care
- ☐ The medication is being used to treat postoperative pain
- ☐ The medication is not being prescribed for pain related to a dental procedure
- ☐ The dose being prescribed is the dose that the patient was stable on prior to discharge
- ☐ The prescriber certifies there is an active treatment plan that includes, but is not limited to, a specific treatment objective and the use of other pharmacological and non-pharmacological agents for pain relief as appropriate
- ☐ The prescriber certifies there has been an informed consent document signed and an addiction risk assessment has been performed
- ☐ The prescriber certifies that a written/signed agreement between prescriber and patient addressing issues of prescription management, diversion, and the use of other substances exists.

☐ **Initial Request for Opioid Cough Medications**

- ☐ The patient is 18 years of age or older
- ☐ The quantity limit override requests involve an FDA-approved indication
- ☐ The quantity limit override requests involving off-label indications must meet off-label guideline approval criteria

☐ The maximum doses specified under the quantity restriction have been tried for an adequate period of time and been deemed ineffective in the treatment of the patient's disease or medical condition
☐ If lower doses have not been tried, there is clinical support (i.e., clinical literature, patient attributes, or characteristics of the drug) that the number of doses available under the quantity restriction will be ineffective in the treatment of the member's disease or medical condition
☐ Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information
☐ Higher dose or quantity is supported by one of the following compendia:
- American Hospital Formulary Service Drug Information
- Micromedex DRUGDEX System

☐ **Initial Request for Long-Acting Opioids**

☐ The patient's diagnosis of cancer
☐ The patient is receiving opioids as part of end-of-life care
☐ The patient has moderate to severe chronic pain that is non-neuropathic
☐ None of the following:
- ☐ For use as an as-needed PRN analgesic
- ☐ For pain that is mild or not expected to persist for an extended period of time
- ☐ For acute pain
- ☐ For postoperative pain, unless the patient is already receiving chronic opioid therapy prior to surgery, or if postoperative pain is expected to be moderate to severe and persist for an extended period of time

☐ Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 4 week) trial of a short-acting opioid (Document drug(s), dose, duration and date of trial)
☐ Unless contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (Document drug(s), dose, duration and date of trial)
☐ Unless contraindicated, the patient has not exhibited an adequate response to at least 6-8 weeks of treatment with a tricyclic antidepressant titrated to a therapeutic dose (Document drug(s), dose, duration and date of trial)
☐ Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 4 week) trial of a short-acting opioid (Document drug(s), dose, duration and date of trial)

☐ **Initial Request for Brand Butrans, generic buprenorphine patch, Belbuca**

☐ The patient is being treated for pain severe enough to require daily, around-the-clock, longer-term opioid treatment
☐ None of the following:
- ☐ For use as an as-needed PRN analgesic
- ☐ For pain that is mild or not expected to persist for an extended period of time
- ☐ For acute pain
- ☐ For opioid dependence

☐ The patient is not receiving other long-acting opioids concurrently

☐ **Continuation of Therapy for Long-Acting Opioids**

- Documentation has been provided addressing ALL of the following

☐ Treatment goals are defined, including estimated duration of treatment
☐ Treatment plan includes the use of a nonopioid analgesic and/or nonpharmacologic intervention
☐ Patient demonstrates meaningful improvement in pain and function using a validated instrument (e.g., Brief Pain Inventory)

☐ Patient has been screened for substance abuse/opioid dependence using a validated instrument (e.g., DAST-10)
☐ Rationale for not tapering and discontinuing
☐ Patient has been screened for comorbid mental health
☐ Prescriber has identified concurrently prescribed controlled substances from state prescription drug monitoring program (PDMP)
☐ If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression
☐ Total daily morphine equivalent dose