



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

Effective May 1, 2018

You can complete this form and fax it to Health Alliance Pharmacy Department at 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 Your Health Alliance for providers. If you have questions, call 1-800-851-3379, option 4.

Section A—Member Information				
Today's Date:	First Name:	Last Name:		
Member ID #:	Address:			
City:	State:	ZIP code:		
Phone:	Date of Birth:			
Primary Insurance:				
Is the requested medication <b>new</b> <input type="checkbox"/> or a <b>continuation of therapy</b> <input type="checkbox"/> ? If so, what is the start date? _____				
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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				
<b>Include all opioid drugs the member is currently using.</b>				
Drug Name	Strength	Quantity	Days Supply	Directions for Use
Diagnosis (Please provide specific details.):			ICD-10 code(s):	
<input type="checkbox"/> Request is not urgent <input type="checkbox"/> Request is urgent <input type="checkbox"/> I certify that the information provided is true and accurate to the best of my knowledge.				
Prescriber's Signature _____		Date _____		
Section D—Treatment Details <i>Please read carefully and complete ALL fields that apply. Refer to <a href="#">this document</a> for MED conversion factors. Supporting chart documentation is required.</i>				
1. Cancer treatment, sickle cell disease and hospice				
Is member receiving opioid due to cancer treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please complete the following:</b>				
Cancer type: _____		Date of diagnosis: _____		
Is member receiving opioid due to sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please complete the following:</b>				
Date of diagnosis: _____				
Is member receiving hospice services? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Approval is for 12 months.</b>				
<b>Note: Completion of remaining sections is NOT required if treating cancer, sickle cell disease or hospice-enrolled patients.</b>				

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**2. MED >100mg per day: ANY treatment unrelated to cancer or sickle cell disease; member is not in hospice\*†**

Has provider seen member in the last 6 months?  Yes  No  
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  
Has member been escalated to the requested dose?  Yes  No  
Has provider discussed the risks of opioid treatment with member?  Yes  No  
Does provider have a pain contract with member restricting the prescribing of pain medication to up to 2 providers?  Yes  No  
**If applicable, list other provider:** \_\_\_\_\_  
Does provider order a urine toxicology screen for member at least annually?  Yes  No **Attach the most recent test results.**  
Has provider reviewed member's state prescription monitoring program at least once in the last 3 months?  Yes  No  
Does provider's treatment plan include 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 <100mg MED?  Yes  No **If no, indicate why:**  
\_\_\_\_\_  
\_\_\_\_\_

**3. Non-preferred long-acting opioids (Avinza, Embeda, Exalgo, Hysingla ER, Kadian, Nucynta ER, Oxycontin, Xtampza ER, Zohydro ER) unrelated to cancer or sickle cell disease; member is not in hospice\*†**

Has provider seen member in the last 3 months?  Yes  No  
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  
Has member been escalated to the requested dose?  Yes  No  
Has provider discussed the risks of opioid treatment with member?  Yes  No  
Has member been on an equivalent of at least 60mg of morphine per day?  Yes  No  
Does member have a history of failure, contraindication or intolerance to a 60-day trial of either of the following?  
 Generic fentanyl transdermal patch (Duragesic)  Generic morphine sulfate ER tablet (MS Contin)  
**Document dose, duration and dates of trial:** \_\_\_\_\_  
Does member have a history of substance abuse requiring an abuse deterrent formulation, or does the provider feel the member should be prescribed an abuse deterrent formulation given the member's medical history?  Yes  No **If yes, attach relevant documentation.**  
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 therapies for short-term use.**

**4. Tramadol extended-release (generic Ultram ER) unrelated to cancer or sickle cell disease; member is not in hospice\*†**

Has provider seen member in the last 3 months?  Yes  No  
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  
Has member been escalated to the requested dose?  Yes  No  
Has provider discussed the risks of opioid treatment with member?  Yes  No  
Does member have a history of failure, contraindication or intolerance to a 30-day trial of tramadol IR?  Yes  No  
**Document dose, duration and date of trial:** \_\_\_\_\_

**5. Short-acting (immediate-release) non-preferred opioids (Nucynta) unrelated to cancer or sickle cell disease; member is not in hospice\*†**

Has provider seen member in the last 3 months?  Yes  No  
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  
Has member been escalated to the requested dose?  Yes  No  
Has provider discussed the risks of opioid treatment with member?  Yes  No  
Does member have a history of failure, contraindication or intolerance to a 30-day trial of a Tier 1 short-acting opioid? (These include but are not limited to hydrocodone, oxycodone and morphine.)  Yes  No  
**Document drug(s), dose, duration and date of trial:** \_\_\_\_\_

*\*Approval for chronic pain treatment: 6 months at current or calculated MED level at time of request*

*†Approval for short-term post-operative pain treatment: 2 months at calculated MED level*