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 E 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—Treatment of acute pain – Plans issued in the state of Illinois only

Based on recommendations published by the CDC and expert consensus, Illinois requires insurers to limit opioid prescriptions, when prescribed to treat acute pain, to a 7-day supply or less.

Is it medically necessary for the member to receive greater than a 7-day supply? ❑ Yes ❑ No

Provide notes and/or a brief description explaining why it isn't appropriate to fill the first prescription for a 7-day supply. (e.g., complex procedure, complications due to surgery, infection, or injury):

Section B—Member Information

Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	ZIP:
Phone:	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 C—Provider Information

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

Section D—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 _____

continued on next page

Section E—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. 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