Physician Request Form for Opioid Containing Products
Fax to Pharmacy Services at 1-855-829-2872, or call 1-855-251-0966
to speak to a representative. ***Form must be completed for processing***.

AmeriHealth Caritas Delaware

Patient name:_____ Patient ID: _____

Patient address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Prescriber name: _____ NPI: _____

Prescriber address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Contact name: _____

Does the patient have cancer, sickle cell or are they in hospice? ☐Yes ☐ No

Diagnosis: _____

Requested drug name, strength and dosage form:_____

Directions: _____ Duration of therapy: _____

FOR INITIAL REQUESTS

Prescriber attests to the following:

- For long-acting products, the diagnosis is chronic pain and requires daily, around the clock, opioid medication. ☐Yes ☐No
- For long acting products, the prescriber attests that the member is treatment experienced with a history of short acting opioids. ☐Yes ☐No
- If the request is for a dose or day supply greater than the current restriction, provide documentation of medical necessity for the requested dose in addition to the current pain regimen (i.e. medication name, strength, duration) below or submit along with this form. _____

  _____
- Has the patient tried non-pharmacological treatment for their pain? ☐ Yes ☐ No
- Has the patient tried at least two non-opioid containing pain medications? ☐ Yes ☐ No
  Please list the non-opioid containing pain medications that have been tried: _____

  _____
- Is the patient taking a benzodiazepine? ☐Yes* ☐No

  ** If yes, the prescriber attests to discussing the risks of using opioids and benzodiazepines together with the patient:* ☐ Yes ☐ No
  Provide documentation as to why the use of an opioid and benzodiazepine is necessary: _____

  _____

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- Is the patient taking a muscle relaxant? ☐Yes* ☐No
  **If yes, the prescriber attests to discussing the risks of using opioids and muscle relaxants together with the patient:* ☐Yes ☐No
  Provide documentation as to why the use of an opioid and muscle relaxant is necessary: _____

  _____

- The prescriber attests that urine drug screens will be completed every 6 months and if illicit drugs are found, identifying the patient as high risk, the heightened risk of overdose will be explained to the patient. ☐Yes ☐No

- Does the patient have a high-risk condition as stated in the CDC guidelines (ex. sleep apnea or other causes of sleep-disordered breathing, patients with renal or hepatic insufficiency, older adults, pregnant women, patients with depression or other mental health conditions, and patients with alcohol or other substance use disorders)? ☐Yes* ☐No
  **If yes, the prescriber attests to discussing heightened risks of opioid use and has educated the patient on naloxone use and has considered prescribing naloxone.* ☐Yes ☐No

- The prescriber attests that urine drug screens will be completed every 6 months and if illicit drugs are found, the patient will be identified as high risk and the heightened risk of overdose will be explained to the patient. ☐Yes ☐No

- The prescriber attests to discussing with the patient the level of risk for opioid abuse/overdose with the dose/duration prescribed and has the patient's signature on file acknowledging eduation. ☐Yes ☐No

- The prescriber attests to discussing history of substance abuse and the risks associated with opioid overdose/abuse, and has the patient's signature on file acknowledging eduation. ☐Yes ☐No

- The prescriber attests that the member has entered into a pain management agreement. ☐Yes ☐No*
  **If no, is the member currently residing in a facility?* ☐Yes ☐No

- The prescriber attests to checking the Delaware PDMP for patient history. ☐Yes ☐No

- If the request is for a non-preferred opioid, the patient must meet the above criteria and have a trial and failure or intolerance with at least two preferred opioid medications. Please list medications tried: _____

  _____

Prescriber Signature: _____ **Print Name:** _____ **Date**: _____

FOR RENEWAL REQUESTS

Prescriber attests to the following:

- The dose requested has been titrated down from the previous authorization. ☐Yes ☐No*
  ** If no, provide an explanation for the continued dosing at the requested amount or a proposed plan for titration going forward.*

  _____

  _____

  _____

- Is the patient taking a benzodiazepine? ☐Yes* ☐No

  **If yes, the prescriber attests to discussing the risks of using opioids and benzodiazepines together with the patient* ☐Yes ☐No
  Provide documentation as to why the use of an opioid and a benzodiazepine is necessary: _____

  _____

- Is the patient taking a muscle relaxant? ☐Yes* ☐No

  **If yes, the prescriber attests to discussing the risks of using opioids and muscle relaxants together with the patient* ☐Yes ☐No

  Provide documentation as to why the use of an opioid and a muscle relaxant is necessary: _____

  _____

- The prescriber has provided urine drug screen (UDS) dates (every 6 months): UDS dates: _____

  _____

  - Positive for illicit drugs? ☐Yes* ☐No
  - Positive for opioids? ☐Yes ☐No**

    *If illicit drugs are found, the prescriber attests to identifying the patient as high risk and explained the heightened risk of overdose to the patient. ☐Yes ☐No

    **If opioids are not found on the urine drug screen, provide documentation as to why the patient needs to continue therapy or submit along with this form. _____

    _____

- The prescriber attests to checking the Delaware PDMP for patient history. ☐Yes ☐No

- Does the patient have a high-risk condition as stated in the CDC guidelines (ex. sleep apnea or other causes of sleep-disordered breathing, patients with renal or hepatic insufficiency, older adults, pregnant women, patients with depression or other mental health conditions, and patients with alcohol or other substance use disorders)? ☐Yes* ☐No

  **If yes, the prescriber attests to discussing heightened risks of opioid use and has educated the patient on naloxone use and has considered prescribing naloxone.* ☐ Yes ☐ No

Prescriber Signature: _____ **Print Name:** _____ **Date**: _____