

# Medicare D Request for Opioid Therapy Evaluation

FAX 1-800-956-2397

Patient Name: (Please Print)	
Patient ID Number:	Patient Birthdate:
MD Name:	MD Specialty:
MD Phone #:	MD Fax #:
MD NPI#	

For more information on the point of sale opioid edits, the policy, *Medicare Part D Formulary-Level Opioid POS Edits*, can be viewed at <https://www.excellusbcbs.com/wps/portal/xl/prv/drg/policies/>

**Requested Drug Name:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

New Start     Continued Therapy StartDate: \_\_\_\_\_

Please list all of the opioids that the patient is currently taking to treat their pain:

\_\_\_\_\_

\_\_\_\_\_

**I attest that ALL of the opioids in the patient's treatment regimen listed above are necessary and appropriate.**

Please list all previous therapies that the patient has attempted and their outcomes:

Drug Name \_\_\_\_\_ Dates of Use \_\_\_ to \_\_\_ Outcome \_\_\_\_\_

Drug Name \_\_\_\_\_ Dates of Use \_\_\_ to \_\_\_ Outcome \_\_\_\_\_

Drug Name \_\_\_\_\_ Dates of Use \_\_\_ to \_\_\_ Outcome \_\_\_\_\_

**Please indicate the MME dose warranted to adequately manage the patient's pain.** (For additional information on calculating the morphine milligram equivalent (MME) dose for a patient taking one or more opioid medications, please refer to <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-vFeb-2018.pdf> OR [https://www.cdc.gov/drugoverdose/pdf/calculating\\_total\\_daily\\_dose-a.pdf](https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf)). Online calculators/apps, such as the *CDC Opioid Guideline App*, are also available to assist in calculating a total MME amount.

(NOTE: The accumulated MME amount that you select below will be the new limit at which the patient's opioid prescription(s) will be subject to. The patient will require another coverage determination once they exceed the newly selected limit.)

- \_\_\_ The provider attests that no maximum limit for accumulated MME per day be set for this patient
- \_\_\_ The provider attests that this patient be limited to a maximum accumulated MME dose up to 1000 mg/day
- \_\_\_ The provider attests that this patient be limited to a maximum accumulated MME dose of up to 800mg/day
- \_\_\_ The provider attests that this patient be limited a maximum accumulated MME dose of \_\_\_\_\_mg/day

I certify that the above information is true and accurate to the best of my knowledge. Please add your electronic signature below or print this document and provide your handwritten signature to avoid delays.

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_