univera HEALTHCARE

Opioid Therapy Evaluation
Medicare-D

Drug Evaluation Request Form

Complete this form and fax to:
Fax #: 1-800-956-2397
Urgent Request Only Fax: 1-800-208-4050

For Assistance Completing this form:
Pharmacy Help Desk Fax: 1-800-956-2397
Phone: 1-800-499-1275

Complete ALL the following Patient/Prescriber Information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #	Patient Birthdate:
List Patient Allergy (If Any)	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Select one Medication/Medical and Provide Dispensing Information

Medication (HCPCS)	Dose	Frequency	Weight (lbs. or kg)	Procedure Code

Diagnosis/ICD-10:

Is this request for a: ☐ New Start **OR** ☐ Continuation of Therapy (recertification)? Start Date: _____

Questions/Indications for Medical Necessity

** **See the Medicare-Part D Formulary Level Cumulative Opioid Point of Sale Edits Policy (Medicare D-111) for full criteria** @ Prescription Drug Policies | Providers | Univera Healthcare **

Current Opioid Prescriptions

1. List all **current** opioids the patient is taking to treat pain?

Drug Name	Strength & Dosing	Period of use	Outcomes
		Start: End:	
		Start: End:	

2. **Prescriber Attestation:**
_____ The prescriber attests, ALL the opioids in the patient's treatment regimen listed above are necessary and appropriate

Previous Opioid Therapy

3. List all **previous** therapies the patient has attempted and their outcomes:

Drug Name	Strength & Dosing	Period of use	Outcomes
		Start: End:	
		Start: End:	

4. Indicate the MME dose warranted to adequately manage the patient's pain. (For additional information on calculating the MME dose for a patient taking one or more opioid medications, please refer to:
https://www.cdc.gov/opioids/providers/prescribing/pdf/calculating-total-daily-dose.pdf **OR**
https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0
Online calculators/apps are also available to assist in calculating a total MME amount.

(*NOTE: The accumulated MME amount 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.)

Prescriber Attestation:
_____The prescriber attests no maximum limit for accumulated MME per day be set for this patient
_____The prescriber attests this patient be limited to a maximum accumulated MME dose up to 1000 mg/day
_____The prescriber attests this patient be limited to a maximum accumulated MME dose of up to 800mg/day
_____The prescriber attests this patient be limited a maximum accumulated MME dose of _____mg/day

*Prescriber Signature: _____ Date: _____
I certify the above is true and accurate to the best of my knowledge