Neighborhood Health Plan OF RHODE ISLAND™

Short-Acting Opioid Form
Fax 1-866-423-0945
Pharmacy Dept. Phone 401-427-8200

This form is to be used by participating physicians and providers to obtain coverage. Please complete the form by providing all of the following information. Fax the completed form to Neighborhood at **1-866-423-0945**. For real time Coverage Determination decisions, please go to Cover My Meds: https://www.covermymeds.com/epa/caremark/.

Short-Acting Opioid Prior Authorization Form

(For daily doses of 90 MMEs or greater)

Enrollee's Name		Date of Birth
Enrollee's Address		
City	State	Zip Code
Phone	Enrollee's Member ID #	

Important Note: Expedited Decisions
If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. ☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED A DECISION WITHIN 24 HOURS**

Prescriber's Information		
Name and NPI		
Address		
City	State	Zip Code
Office Phone	Fax	
Prescriber's Signature		Date

Diagnosis and Medical Information		
Medication:	Strength and Route of Administration:	Frequency:
New Prescription OR Date Therapy Initiated:	Expected Length of Therapy:	Quantity:

Height/Weight:	Drug Allergies:	Diagnosis:

Criteria Questions			
1	Is the requested drug being prescribed for pain associated with a cancer diagnosis, terminal condition, or pain being managed through hospice or palliative care? [If yes, then no further questions, unless it is Non-Formulary. If the medication is Non-Formulary, please proceed to question 5.]	Yes	No
2	Is the patient opioid naïve ? [If no, then skip to question 4.]	Yes	No
3	I s this request for greater than 30 morphine milligram equivalents per day (MME/day) OR for greater than 20 tablets? [Note: The State of Rhode Island Opioid Prescribing Laws state that patients who are opioid naïve shall not exceed 30 MME/day for a maximum total of 20 tablets.]	Yes	No
4	Does the prescriber attest to the following: ▪ The prescriber understands the findings of the Centers for Disease Control and Prevention's (CDC's) Guideline for Prescribing Opioids for Chronic Pain (2016, 2017) which concluded that long term opioid therapy is associated with increased risk for serious harm (opioid use disorder, overdose, and death) in a dose dependent manner: A) Greater than or equal to 50 morphine milligram equivalents per day (MME/day) significantly increases the risk for harm and indicates need to reassess, B) Greater than or equal to 90 MME/day sharply increases risk for harm and requires justification of risk, C) Greater than or equal to 200 MME/day is associated with overdose (OD) death. ▪ The prescriber acknowledges that the risk of serious harm is markedly increased with concurrent use of benzodiazepines (BZD) and other Central Nervous System (CNS) depressants. ▪ The patient has a prescription for OR is in possession of naloxone. ▪ The prescriber has counseled the patient (and the patient's cohabitant(s), if available) on how to obtain and administer naloxone. ▪ The patient has tried and failed non-pharmacologic therapy and/or nonopioid therapy in combination with a LOW DOSE opioid to treat pain. If patient is naïve to opioids, the patient has tried and failed non-pharmacologic therapy and non-opioid therapy. ▪ **For continuation of therapy requests**: the original opioid dosing was titrated down from the initial authorization or in the prescriber's clinical opinion, it is inappropriate to decrease the dose for this patient. [If yes, then no further questions, unless it is Non-Formulary. If the medication is Non-Formulary, please proceed to question 5.]	Yes	No
5	For Non-Formulary drug requests, has the patient tried and failed 2 formulary alternatives or has a medical reason why the formulary alternatives are not appropriate?	Yes	No

	Please provide drugs failed or rationale for why formulary alternatives would not be appropriate: _____ _____ _____		

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's Signature _____ NPI _____ Date _____