**The CDC’s Opioid Guideline Mobile App is designed to help providers with Morphone Milligram Equivalent (MME) calculations when prescribing opioids. The CDC app is available for free download on Google Play for Android devices and in the Apple Store for iOS devices**

**NOTE:** Form must be completed in its entirety for processing.

<table>
<thead>
<tr>
<th>Select Drug</th>
<th>Drug Strength</th>
<th>Dosing Directions</th>
<th>Requested Quantity per 90 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine/APAP tablets</td>
<td></td>
<td></td>
<td>Qty per 90 days</td>
</tr>
<tr>
<td>Codeine/APAP solution</td>
<td></td>
<td></td>
<td>Qty mls per 90 days</td>
</tr>
<tr>
<td>Dihydrocodeine/APAP/Caffeine</td>
<td></td>
<td></td>
<td>Qty per 90 days</td>
</tr>
<tr>
<td>Hydrocodone/APAP tablets</td>
<td></td>
<td></td>
<td>Qty per 90 days</td>
</tr>
<tr>
<td>Hydrocodone/APAP elixir</td>
<td></td>
<td></td>
<td>Qty mls per 90 days</td>
</tr>
<tr>
<td>Hydrocodone/APAP solution</td>
<td></td>
<td></td>
<td>Qty mls per 90 days</td>
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<tr>
<td>Hydrocodone/buprofen tablets</td>
<td></td>
<td></td>
<td>Qty per 90 days</td>
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<tr>
<td>Nalocet tablets</td>
<td></td>
<td></td>
<td>Qty per 90 days</td>
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<tr>
<td>Oxycodone/APAP tablets</td>
<td></td>
<td></td>
<td>Qty per 90 days</td>
</tr>
<tr>
<td>Oxycodone/APAP solution</td>
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<td>Qty mls per 90 days</td>
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<tr>
<td>Oxycodone/ASA tablets</td>
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<td>Qty per 90 days</td>
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<tr>
<td>Oxycodone/buprofen tablets</td>
<td></td>
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<td>Qty per 90 days</td>
</tr>
<tr>
<td>Tramadol/APAP tablets</td>
<td></td>
<td></td>
<td>Qty per 90 days</td>
</tr>
</tbody>
</table>

***Check www.fepblue.org/formulary to confirm which medication is part of the patient’s benefit***

****Non-covered branded medications must go through prior authorization and the formulary exception process****

Is this request for brand or generic?  □Brand  □Generic

1. Will the patient be using the IR opioid concurrently with Lucemyra, methadone (Dolophine), or a buprenorphine medication such as Suboxone for opioid addiction?  □Yes* (*If YES, please select buprenorphine, Lucemyra, or methadone below)  □No

   □Buprenorphine: Please answer the following questions:
   a. Has the patient had a recent injury, accident or surgery that requires the addition of an opioid to their therapy or has the patient been started on an opioid addiction medication?  □Yes  □No
   b. Do you agree the patient will be tapered off of the opioid within 30 days?  □Yes*  □No

   *If YES, specify medication(s), strength, and quantity needed for the 30 day taper below:

   □Lucemyra  
   □Methadone: Do you agree the patient will be tapered off of methadone or the requested opioid within 30 days?  Select answer below:

   □Methadone: Specify medication, strength, and quantity needed every 30 days below:

   □Opioid: Specify medication(s), strength, and quantity needed every 30 days below:

   □No: Specify strength and quantity needed for a 30 day supply:

2. Is the prescribing physician a board certified oncologist?  □Yes  □No

**PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS**

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. Prescriber Certification: I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. IR Opioid Combo – FEP Fax Form Revised 1/1/2020
### Page 2 - Physician Completes

| Patient Name: ___________________________ | DOB: ____________________ | Cardholder ID: ____________________________ |

3. What level of pain is the patient being treated for? [ ] Mild [ ] Moderate [ ] Moderate to severe [ ] Severe

4. Is the patient being treated for acute or chronic pain? Please select answer below:
   - [ ] Acute: Does the prescriber agree to discontinue therapy after 30 days? Yes No
   - [ ] Chronic: Does the physician agree to assess the benefits of pain control, for example, by implementing a care plan, to check signs of misuse/abuse using standard lab screening (i.e. urine, blood), and evaluating severity of pain after three months? Yes No

5. Has the patient been on the requested medication continuously for the last 4 months? [ ] Yes [ ] No*
   *If NO, Have alternative treatments, including non-opioid analgesics and other treatment modalities, been ineffective, not tolerated or inadequate for pain control? [ ] Yes [ ] No

6. Have alternative treatments, including non-opioid analgesics and other treatment modalities, been ineffective, not tolerated or inadequate for pain control? [ ] Yes [ ] No

7. Does the prescriber agree to participate in the *Opioid Analgesic REMS program and to monitor for abuse, misuse, addiction, and overdose and discontinue if necessary? [ ] Yes [ ] No
   *For information about Opioid Analgesic REMS please visit: [https://opioidanalgesicrems.com](https://opioidanalgesicrems.com)

8. Will the patient be assessed for signs and symptoms of serotonin syndrome? [ ] Yes [ ] No

9. Will the patient be using the requested medication in combination with alprazolam (Xanax), clonazepam (Klonopin), diazepam (Valium), or lorazepam (Ativan)? [ ] Yes [ ] No

10. Will the patient be using the requested medication in combination with oxazepam (Serax), chlor Diazepoxide (Librium), or clorazepate dipotassium (Tranxene)? [ ] Yes [ ] No

11. Will the patient be taking the requested medication with another immediate release (IR) opioid? [ ] Yes* [ ] No
   *If YES, please specify:

12. **UNDER 18 Years of Age:** Has the patient taken at least three days of **IR OR ER** opioid in the past 180 days? [ ] Yes [ ] No
    **18 Years of Age or Older:** Has the patient taken at least seven days of an **IR OR ER** opioid in the past 180 days? [ ] Yes [ ] No

13. Does the patient’s current opioid pain regimen exceed 300 morphine milligram equivalents (MME) per day? [ ] Yes* [ ] No
   *If YES, please answer the following questions:
   a. Is the patient currently taking an immediate release (IR) opioid? [ ] Yes* [ ] No
      *If YES, please specify all drugs, strengths, and quantities for each IR opioid:

   b. Is the patient currently taking an extended release (ER) opioid? [ ] Yes* [ ] No
      *If YES, please specify all drugs, strengths, and quantities for each ER opioid:

   c. Is the patient’s opioid regimen being adjusted from established therapy? Please select answer below:
      - [ ] YES: Please select one of the following below:
        - This is a change of therapy to a different drug or strength from established therapy. Please specify drug that is being replaced:
        - This is a request to increase quantity for an opioid the member is established on
        - This is a change of therapy to add a new drug or strength to established therapy
      - [ ] NO: The patient is continuing on their currently established opioid regimen
   d. Does the physician agree that the patient’s opioid regimen will be tapered to 300MME? [ ] Yes* [ ] No
      *If YES, please specify which drug will be tapered and what the final quantity will be in a 90 day supply:

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