COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Elixir Opioid Review (200 MME)

Phone: 800-361-4542 Fax back to: 866-414-3453

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Please note that Elixir will process the request as written, including drug name, with no substitution.

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is this request for initial or continuing therapy?

☐ Initial therapy ☐ Continuing therapy

Q2. For CONTINUING THERAPY, please provide the start date (MM/YY):

Q3. Please indicate the patient's diagnosis for the requested medication:

- ☐ Pain secondary to a diagnosis of active cancer
- ☐ Pain secondary to a terminal illness
- ☐ Sickle-cell disease
- ☐ Acute pain: post-surgical pain
- ☐ Moderate-to-severe chronic pain
- ☐ Other

Q4. If the patient's diagnosis is OTHER, please specify below:

Q5. Does the prescriber attest to utilizing the safety measures outlined in the Centers for Disease Control and Prevention (CDC) Guideline for Prescribing Opioids for Chronic Pain?

☐ Yes ☐ No

Q6. Has the prescriber reviewed the appropriate state prescription drug monitoring program?

☐ Yes

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Elixir Opioid Review (200 MME)

Phone: 800-361-4542 Fax back to: 866-414-3453

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**

☐ No
☐ Missouri/Guam only: No, my state does not have an available prescription drug monitoring program

Q7. Has the patient been assessed for contraindications to opioid therapy (e.g. significant respiratory depression, known/suspected paralytic ileus, etc.)?

☐ Yes ☐ No

Q8. If patient is female between 18-45 years old, has the prescriber discussed risk of neonatal abstinence syndrome and provided counseling on contraceptive options?

☐ Yes ☐ No ☐ Not applicable

Q9. For post-surgical pain, has the patient been provided instruction on how to integrate their post-operative opioid therapy into their existing medication regimen (including titration of an existing opioid regimen)?

☐ Yes
☐ No
☐ The request is not for post-surgical pain

Q10. Has the patient been counseled on the risks of an opioid overdose and been provided with an opportunity to obtain a prescription or other access to naloxone in addition to their opioid prescriptions?

☐ Yes ☐ No

Q11. Does the prescriber attest that a cumulative daily MME (Morphine Milligram Equivalents) of 200 or greater is medically necessary for this patient?

☐ Yes ☐ No ☐ N/A

Q12. The prescriber may provide any additional rationale in order to justify coverage of the requested medication and quantity.

Prescriber Signature

Date

COVERAGE DETERMINATION REQUEST FORM

EOC ID:
Elixir Opioid Review (200 MME)

Phone: 800-361-4542 Fax back to: 866-414-3453

Elixir manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**