**Note**: Processing may be delayed if information submitted is illegible or incomplete.

If your fax includes the standardized fax form, only the **Member Name**, **DOB**, **ID**, and **Clinical Criteria** need to be completed and faxed as an attachment to process your request.

# ENROLLEE INFORMATION

**Enrollee’s Last Name: Enrollee’s First Name:**

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**Date of Birth: Enrollee’s Medicaid ID (2 letters, 5 numbers, 1 letter):**

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# PRESCRIBER INFORMATION

**Prescriber’s Last Name: Prescriber’s First Name:**

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**Contact Person:**

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**National Provider Identifier (NPI) Number:**

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**Office Phone Number: Office Fax Number:**

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# DRUG INFORMATION

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

**Strength:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Directions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Quantity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Refills:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Enrollee’s Last Name: Enrollee’s First Name:**

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# Clinical Criteria – PRESCRIPTION FILL/REFILL LIMIT

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

1. Patients are limited to a total of four opioid prescription fills per rolling 30 days. What is the clinical rationale for exceeding four fills of any opioid prescription per month?

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1. Please provide current long-acting and short-acting opioid therapy:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medication** | **Start Date** | **Strength** | **Frequency** | **Discontinuation Date** |
|  |  |  |  |  |
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# PREFERRED DRUG LIST

1. Is a non-preferred opioid agent being prescribed? (Please refer to the PDL at <https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf> for a current list of preferred and non-preferred agents.)

[ ]  Yes [ ]  No

If **YES**, please select the most appropriate clinical rationale (questions 4 through 7) for use of a non-preferred agent (form cannot be processed without required explanation):

1. Patient has experienced a treatment failure with a preferred drug.

[ ]  Yes [ ]  No

1. Patient has experienced an adverse drug reaction with a preferred drug.

[ ]  Yes [ ]  No

1. There is documented history of successful therapeutic control with a nonpreferred drug and transition to a preferred drug is medically contraindicated.

[ ]  Yes [ ]  No

*(Form continued on next page.)*

**Enrollee’s Last Name: Enrollee’s First Name:**

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# PREFERRED DRUG LIST (*CONTINUED*)

1. Other (Please specify the clinical reason the patient is unable to use a preferred agent in the same drug class. If necessary, fax additional pages):

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Clinical DRUG REVIEW PROGRAM: FENTANYL MUCOSAL AGENTS

1. Drug name:

[ ]  Actiq® (fentanyl lozenge)

[ ]  Fentora® (fentanyl buccal tablet)

[ ]  fentanyl buccal

[ ]  fentanyl lozenge

## For Actiq®, Fentora®, and any available generics:

1. Is this medication being prescribed to manage breakthrough cancer pain?

[ ]  Yes [ ]  No

1. If **NO**, please list diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you or have you consulted with an Oncologist or Pain Management Specialist?

[ ]  Yes [ ]  No

1. Is the patient already receiving long-acting opioid therapy for underlying persistent pain?

[ ]  Yes [ ]  No

1. If **NO**, please provide clinical reason:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Enrollee’s Last Name: Enrollee’s First Name:**

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# Clinical DRUG REVIEW PROGRAM: FENTANYL MUCOSAL AGENTS (*CONTINUED*)

1. Is the patient tolerant[[1]](#footnote-1) to the opioid therapy currently being used for his/her underlying persistent pain?

[ ]  Yes [ ]  No

1. If **NO**, please provide clinical reason:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Does the quantity prescribed exceed four (4) units per day or 120 units per 30 days?

[ ]  Yes [ ]  No

1. If **YES**, please provide clinical reason:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Clinical EDITs

## Applies to all short acting opioids (SAO), long acting opioids (LAO), Tramadol ER products, Methadone, Soma compound w/codeine, and Fentanyl Mucosal Agents:

## Has the patient’s risks for opioid misuse or abuse been assessed?

[ ]  Yes [ ]  No

1. Document measures taken to monitor for misuse or abuse (i.e., regular Prescription Monitoring Program (PMP) checks, pill count, urine drug screen, pharmacy check)

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**Enrollee’s Last Name: Enrollee’s First Name:**

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# Clinical EDITs *(Continued)*

## New York State Public Health Law requires co-prescribing of an opioid antagonist when an opioid is prescribed for someone with a history of substance use disorder. Have you considered co-prescribing an opioid antagonist?

[ ]  Yes [ ]  No

1. If **NO**, please provide clinical reason:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Tramadol and codeine-containing products:

1. Is the patient being prescribed tramadol or codeine 12 years of age or younger?

[ ]  Yes [ ]  No

1. If **YES**, what is the clinical reason for prescribing a codeine or tramadol containing containing product in a patient < 12 years old despite the contraindications and warnings listed in the manufacturer package insert for this age group?

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# STEP THERAPY

## Nucynta® ER (long-acting opioid):

1. Is the patient naïve to long acting opioid therapy?

[ ]  Yes [ ]  No

1. If **YES**, has your patient experienced a treatment failure or adverse reaction to Nucynta IR (immediate release)?

[ ]  Yes [ ]  No

## Nucynta® IR (short-acting opioid):

1. Has your patient experienced a treatment failure or adverse reaction to tramadol plus 1 other preferred short-acting opioid?

[ ]  Yes [ ]  No

*(Form continued on next page.)*

**Enrollee’s Last Name: Enrollee’s First Name:**

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# STEP THERAPY *(Continued)*

## Tramadol ER (generic of Ultram ER):

1. Has your patient experienced a treatment failure or adverse reaction to immediate release tramadol?

[ ]  Yes [ ]  No

1. If **NO**, is the prescriber willing to change?

[ ]  Yes [ ]  No

## ConZip (tramadol ER):

1. Has your patient experienced a treatment failure or adverse reaction to immediate release tramadol?

[ ]  Yes [ ]  No

1. Has your patient experienced a treatment failure or adverse reaction to tramadol ER (generic of Ultram ER)?

[ ]  Yes [ ]  No

1. If **NO**, is the prescriber willing to change?

[ ]  Yes [ ]  No

## Methadone Products:

1. Is Methadone being prescribed for the treatment of opioid addiction?

[ ]  Yes [ ]  No

If **YES**, Methadone must be billed through a Methadone Maintenance Treatment Program.

1. Has your patient experienced a treatment failure or adverse reaction to a long acting opioid?

[ ]  Yes [ ]  No

*(Form continued on next page.)*

**Enrollee’s Last Name: Enrollee’s First Name:**

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# THERAPEUTIC DUPLICATION

## Two long-acting opioids (applies to LAO, Tramadol ER products, and Methadone):

1. What is the clinical rationale for the patient requiring concurrent use of two or more long-acting opioids?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please list long-acting opioid(s):

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Opioid/Benzodiazepine (applies to all SAO and LAO, Tramadol ER products, Methadone, Soma compound w/codeine, and Fentanyl Mucosal Agents):

1. Are you aware that concurrent use of an opioid and benzodiazepine can increase the risk of respiratory depression and other adverse events?

[ ]  Yes [ ]  No

1. Are you monitoring for these adverse events?

[ ]  Yes [ ]  No

1. What is the clinical rationale for the patient requiring concurrent use of a benzodiazepine and an opioid?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Please list the benzodiazepine product(s):

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1. New York State Public Health Law requires co-prescribing of an opioid antagonist when an opioid and benzodiazepine are prescribed concurrently. Have you considered co-prescribing an opioid antagonist?

[ ]  Yes [ ]  No

1. If **NO**, please provide clinical reason:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Enrollee’s Last Name: Enrollee’s First Name:**

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# THERAPEUTIC DUPLICATION *(Continued)*

## Opioid/Buprenorphine (applies to all SAO and LAO, Tramadol ER products, Methadone, Soma compound w/codeine, and Fentanyl Mucosal Agents):

1. Is the patient currently taking a Buprenorphine product?

[ ]  Yes [ ]  No

1. Are you willing to prescribe a non-opiate analgesic (i.e., NSAID, etc.)?

[ ]  Yes [ ]  No

1. Is the patient having surgery or had an acute event requiring narcotic pain medication?

[ ]  Yes [ ]  No

1. What is the clinical rationale for the patient requiring concurrent use of an opioid and a buprenorphine product?

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**Opioid/Gabapentinoids (applies to all SAO):**

1. Are you aware that concurrent use of an opioid and gabapentin or pregabalin can increase the risk of respiratory depression and other serious adverse events?

[ ]  Yes [ ]  No

1. Are you monitoring for these adverse events?

 [ ]  Yes [ ]  No

1. What is the clinical rationale for the patient requiring concurrent use of gabapentin or pregabalin and an opioid?

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**Enrollee’s Last Name: Enrollee’s First Name:**

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# THERAPEUTIC DUPLICATION *(Continued)*

1. Please list the gabapentinoid product(s):

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## Opioid + CNS Stimulant (applies to all SAO and LAO):

1. What is the clinical rationale for the patient requiring concurrent use of a CNS stimulant and an opioid?:

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1. Please list the name of the CNS stimulant the patient is currently on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Concurrent use of an opioid and CNS stimulant may lead to synergistic effects, which may cause euphoric effects and increased risk for dependence, adverse events (e.g. serotonin syndrome, overdose), and death. Are you aware of this risk and is the patient being monitored for these adverse events?

[ ]  Yes [ ]  No

# MORPHINE MILLIEQUIVALENCE EDIT (MME)

1. Please provide the total MME for the medication being requested. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please provide the total MME for all opioids combined. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Is the patient established on this regimen?

[ ]  Yes [ ]  No

1. If yes, please provide the start date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. For opioid-naïve patients with acute pain:
	1. If the total MME exceeds 50 MME/day, what is the clinical reason for prescribing a high MME regimen?

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* 1. Are you willing to prescribe a lower MME regimen?

[ ]  Yes [ ]  No

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**Enrollee’s Last Name: Enrollee’s First Name:**

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# MORPHINE MILLIEQUIVALENCE EDIT (MME) *(Continued)*

* 1. If yes, please provide regimen:

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1. For opioid-tolerant patients with non-acute pain (> 7 days):
2. If the total MME exceeds 90 MME/day, what is the clinical reason for prescribing a high MME regimen?

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1. Are you willing to prescribe a lower MME regimen?

[ ]  Yes [ ]  No

1. If yes, please provide regimen:

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1. New York State Public Health Law requires co-prescribing of an opioid antagonist when an opioid is prescribed for someone on high dose or cumulative prescriptions that result in ninety morphine milligram equivalents or higher per day. Have you considered co-prescribing an opioid antagonist?

[ ]  Yes [ ]  No

1. If **NO**, please provide clinical reason:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# FREQUENCY/QUANTITY/DURATION (f/Q/D)

## For all SAO and LAO:

1. Does quantity prescribed exceed the recommended dosage? (Please refer to the PDL at <https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf>)

[ ]  Yes [ ]  No

*(Form continued on next page.)*

**Enrollee’s Last Name: Enrollee’s First Name:**

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# FREQUENCY/QUANTITY/DURATION (F/Q/D) *(Continued)*

1. If **YES**, please provide clinical reason:

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## For LAO, Methadone, and Tramadol ER products:

1. For an initial fill for an opioid-naïve patient, please provide a clinical rationale for requesting a long-acting opioid in an opioid-naïve patient.

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1. Does quantity prescribed exceed the per day limit? (Please refer to the PDL at <https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf>)

[ ]  Yes [ ]  No

1. If **YES**, please provide clinical rationale for exceeding the FDA approved/Compendia supported quantity limit:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## For SAO only:

1. NYS Public Health Law prohibits a practitioner from prescribing more than a 7-day supply of an opioid for acute pain in an opioid-naïve patient. What is the clinical rationale for exceeding the 7-day supply initial fill duration limit?

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## For SAO only (for requests that exceed the 90-day duration limit):

1. Are you currently tapering the patient off their short-acting narcotic and attempting to utilize different treatment options? (Alternative non-opioid options can be found at: <https://health.ny.gov/health_care/medicaid/program/opioid_management/docs/non_opioid_alternatives_to_pain_management.pdf> )

[ ]  Yes [ ]  No

*(Form continued on next page.)*

**Enrollee’s Last Name: Enrollee’s First Name:**

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# FREQUENCY/QUANTITY/DURATION (F/Q/D) *(Continued)*

1. Is the patient currently on a long-acting opioid that is being optimized for treatment of the patient’s diagnosis?

[ ]  Yes [ ]  No

1. Has your patient experienced a treatment failure or adverse reaction to a long-acting opioid or is there a contraindication to using a long-acting opioid?

[ ]  Yes [ ]  No

1. Has the patient’s risk for opioid misuse or abuse been assessed?

[ ]  Yes [ ]  No

## For Methadone requests that exceed max of #12 units per day, or #360 units per 30 days:

1. Has the patient been assessed for clinical risks of opioid/substance abuse/addiction?

[ ]  Yes [ ]  No

1. Does the patient have an underlying cardiovascular disorder or history of cardiac arrhythmias?

[ ]  Yes [ ]  No

1. Will the patient periodically be clinically assessed for the need for gradual dosage adjustments?

[ ]  Yes [ ]  No

1. What is the clinical rationale for the patient requiring a dose exceeding #12 units per day?

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| --- | --- | --- |
| Prescriber Signature (Required) |  | Date |
| *I attest that this is medically necessary for this patient and that all of the informaton on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by New York Medicaid.* |

**Fax Number:** 1-800-268-2990

**Billing Questions:** 1-800-343-9000

For clinical concerns or Preferred Drug Program questions, please visit <http://newyork.fhsc.com> or call
1-877-309-9493

1. Patients are considered to be opioid-tolerant if they are taking around-the-clock medicine for one week consisting of at least:

60 mg of morphine; **OR**

25 mcg transdermal fentanyl/hour; **OR**

30 mg of oxycodone; **OR**

8 mg of oral hydromorphone; **OR**

Equianalgesic dose of another opioid daily for a week or longer [↑](#footnote-ref-1)