

General Methadone Transmucosal Fentanyl MAT

## **Opioid Attestation**

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and fax or attach to electronic prior authorization request as soon as possible to expedite this request. Without this information, we may deny the request.

	Please	fax responses to: 1-88	8-260-9836	
Date of request	Reference number	Patient	Date of birth	Member ID
Pharmacy name		Pharmacy NPI	Telephone	Fax
Prescriber		Prescriber NPI	Telephone	Fax
Medication and strength		Directions for use		Qty/Days supply
Medication and strength		Directions for use		Qty/Days supply
Medication and strength		Directions for use		Qty/Days supply
Medication and strength		Directions for use		Qty/Days supply
must include a spec treatment, hospice,	ific end date below. For p palliative or end-of-life ca	per wants an attestation to be latients receiving opioids for the re, the consultation is not requi	e treatment of pain relating to red for authorization, but it is	o active cancer s still encouraged.
	-	ersion Factor document to ca		-
☐ > 120 I ☐ > 200 ☐ ☐ Chronic no ☐ < 120 I ☐ > 120 I ☐ > 200 ☐ ☐ Active cand ☐ < 120 I ☐ > 120 I	cancer pain. Specify MM but ≤ 200 per day (Compl MME per day (Complete s n-cancer pain (> 42 days MME per day (Complete s but ≤ 200 per day (Complete s but ≤ 200 per day (Complete s ber pain, hospice, palliativ MME per day (Pharmacy but ≤ 200 per day (Complete s	ete section 3 and 4); or section 3 and 4; supply medical of opioid therapy is needed in a sections 2 and 4) ete section 2 thru 4); or section 2 thru 4; supply medical e, or end-of-life care. Specify M may re-submit claim with EA C	a 90 day period). Specify MM I records supporting the med IME: ode: 85000000540); or	dical need)
2. Chronic Opioid				

## Criteria for chronic use of opioids for the treatment of non-cancer pain:

- Your patient has an on-going clinical need for chronic opioid use at the prescribed dose (more than 42 days per 90-day calendar period) that is documented in the medical record; AND
- · Your patient is using appropriate non-opioid medications, and/or non-pharmacologic therapies; OR
- Your patient has tried and failed non-opioid medications and non-pharmacologic therapies for the treatment of this pain condition; AND

- · For long-acting opioids, your patient has tried a short-acting opioid for at least 42 days or there is clinical justification why short-acting opioids were inappropriate or ineffective; AND · You have recorded your patient's baseline objective pain and function scores and conduct periodic assessments in order to demonstrate clinically meaningful improvements in pain and function; AND · You have screened your patient for mental health disorders, substance use disorder, naloxone use; AND You conduct periodic urine drug screens of your patient; AND · You check the PDMP to determine if your patient is receiving other opioid therapy and concurrent therapy with benzodiazepines and other sedatives; AND · You discussed with your patient the realistic goals of pain management therapy, including discontinuation of opioid therapy as an option during treatment; AND · You have confirmed that your patient understands and accepts these conditions and your patient has signed a pain contract or informed consent document. The requested treatment is medically necessary, does not exceed the medical needs of the member, and is documented your patient's medical record? □ No Do you attest that all of the above criteria are met, or there is documentation in your patient's medical record for why one or more are not applicable? ☐ Yes □ No 3. Opioid High Dose Attestation Clinical reason for opioid doses MME > 120 per day: · Your patient is currently on chronic opioid therapy and the patient has a medically necessary need requiring a temporary escalation in opioid dosage that exceeds 120 MME but less than or equal to 200 MME per day, for no more than 42 days; ☐ You are prescribing opioids for an acute medically necessary need, you have reviewed the Prescription Monitoring Program (PMP) and understand your patient is on chronic opioid therapy from another prescriber, and you have coordinated care with the other opioid prescriber; OR You are the prescriber of the chronic opioid therapy: OR • D Your patient is following a tapering schedule with a starting dose > 120 MME but less than or equal to 200 MME per day; OR • Or Your patient has a medically necessary need to exceed 120 MME per day documented in the medical record; Check the box below that applies: ☐ You are a board certified pain management specialist; OR You have successfully completed a minimum of twelve category I continuing education hours on chronic pain management within the previous four years. At least two of these hours must have been dedicated to substance use disorders; OR ☐ You are a pain management physician working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; OR
- ☐ You have a minimum of three years of clinical experience in a chronic pain management setting, and at least thirty percent of their current practice is the direct provision of pain management care; OR ☐ Your patient requires > 120 MME per day for active cancer pain, palliative care, end of life care or is in hospice; OR ☐ You consulted with a pain management specialist regarding use of high dose opioids (> 120 MME per day) for this patient through one of the methods below and it is documented in the medical record: An office visit with patient, prescriber and pain management specialist; OR · Telephone, electronic, or in-person consultation between the pain management specialist and the prescriber; OR · An audio-visual evaluation conducted by the pain management specialist remotely where the patient is present with either the physician or a licensed health care practitioner designated by the physician or the pain management specialist; AND The requested treatment is medically necessary, does not exceed the medical needs of the member, and is documented in vour patient's medical record? Yes ☐ No Do you attest that all of the above criteria are met, or there is documentation in your patient's medical record for why one or ☐ Yes more are not applicable? ☐ No 4. For temporary escalations this attestation will expire in 42 days; for all others this attestation will expire in 12 months unless you specify that you would like an earlier end date. Please specify if you would like an earlier end date: \_ By signing below, I certify that the information on this form is true and understand that any misrepresentation or any concealment of any information requested may subject me to an audit. Supporting documentation is required for requests exceeding 200 MME per day. Prescriber signature Prescriber specialty Date



## Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TRS: 711, Email AppealsDepartmentInquiries@Premera.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <a href="https://www.hhs.gov/ocr/office/file/index.html">https://www.hhs.gov/ocr/office/file/index.html</a>.

## Language Assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-807-7310 (TRS: 711). 注意: 如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 800-807-7310 (TRS: 711)。 CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-807-7310 (TRS: 711). 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-807-7310 (TRS: 711) 번으로 전화해 주십시오.

<u>ВНИМАНИЕ</u>: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-807-7310 (служба коммутируемых сообщений: 711).

<u>PAUNAWA</u>: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-807-7310 (TRS: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-807-7310 (служба комутованих повідомлень: 711). ប្រយ័គ្នះ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នកា ចូរ ទូរស័ព្ទ 800-807-7310 (TRS: 711)។

<u>注意事項</u>:日本語を話される場合、無料の言語支援をご利用いただけます。800-807-7310 (TRS:711) まで、お電話にてご連絡ください。

<u>ማስታወሻ:</u> የሚናገሩት ቋንቋ ኣማርኛ ከነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-807-7310 (በስልክ ማገናኛ አንልግሎት: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-807-7310 (TRS: 711). (711 :درق اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-807-7310 (رقم خدمة ترحيل الاتصالات للصم والبحم: पिਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-807-7310 (TRS: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

<u>ACHTUNG</u>: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-807-7310 (TRS: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-807-7310 (TRS: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-807-7310 (TRS: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-807-7310 (SRT : 711).

<u>UWAGA</u>: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-807-7310 (TRS: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-807-7310 (TRS: 711).

<u>ATTENZIONE</u>: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-807-7310 (TRS: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TRS: 711) (TRS-807-807-800 تماس بگیرید.