Please complete ALL information below and fax your request to 1-888-671-5285

Nucynta® Coverage Determination Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Non-Formulary**- Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

❑ **Step Therapy**- Request is for an exception to try another drug before the requested drug being prescribed.

❑ **Quantity Limit**- Request is for an exception to the plan's quantity limit.

Quantity per DAY requested? _________

Select the diagnosis below:

❑ Management of acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate

❑ Other diagnosis: _________________________________ ICD-10 Code(s): _________________________________

Clinical information:

Is the patient's pain associated with cancer? ❑ **Yes** ❑ **No**

If **yes**, please provide cancer diagnosis: ____

If **no**, does the patient have chronic non-cancer pain? ❑ **Yes** ❑ **No**

Initial authorization (patient new to high dose opioid therapy):

Is the patient opioid tolerant as demonstrated by adherence to one of the following regimens for at least one week? ❑ **Yes** ❑ **No**

- 25mg of oral oxymorphone daily
- 30mg of oxycodone daily
- 60mg of oral morphine daily
- 8mg of oral hydromorphone daily

Is the patient opioid tolerant as demonstrated by adherence to an equianalgesic dose of another opioid for at least one week? ❑ **Yes** ❑ **No**

If **yes**, please provide the name, dose, and duration of the medication tried:_______________________________________
____

Has the patient been evaluated for non-opioid prescription pharmacologic treatment prior to initiation of high dose opioid therapy? ❑ **Yes** ❑ **No**

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Nucynta® Coverage Determination Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Continuation (patient continuing high dose opioid therapy):

Is the patient tolerating the requested medication appropriately? ❑ **Yes** ❑ **No**

Does the patient have improved functioning? ❑ **Yes** ❑ **No**

Is the patient being treated for substance abuse? ❑ **Yes** ❑ **No**

Has the patient's pain been assessed within the last 6 months? ❑ **Yes** ❑ **No**

Select the medication(s) the patient has a history of trial and failure, or intolerance to:

❑ Endocet
❑ Hydrocodone-acetaminophen
❑ Hydrocodone-ibuprofen
❑ Hydromorphone
❑ Lorcet HD
❑ Morphine sulfate
❑ Oxycodone
❑ Oxycodone-acetaminophen
❑ Oxycodone-aspirin
❑ Oxycodone-ibuprofen
❑ Oxymorphone
❑ Other drugs in the same class. Please specify: ____
❑ Other therapeutic equivalent alternatives. Please specify: ______________________________________

Quantity limit requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? ❑ **Yes** ❑ **No**

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? ❑ **Yes** ❑ **No**

If **yes,** please specify:____

Prescriber Attestation of Medical Necessity:

Does the provider attest that the current medication regimen, exceeding the current cumulative morphine equivalent dose (MED) threshold, is medically required? ❑ **Yes** ❑ **No**

Requests exceeding 7 Day Supply Limit for Opioid Naïve Patients:

Does the provider attest that in his/her clinical judgment, the requested day supply exceeding the current 7 day supply limit is medically necessary? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

____

____

Please note: This request may be denied unless all required information is received.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of FutureScripts. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**