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

Opioid-Medication Assisted Treatment (MAT) Combination Therapy Coverage Determination Request Form

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 diagnosis below:

❑ Cancer pain

❑ Other pain. Please specify: _____

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

Cancer Pain:

Is the requested medication being used for the management of **active** cancer pain? ❑ **Yes** ❑ **No**

End of Life Care (Palliative Care):

Is the patient on opioid pain medication for end of life (palliative) care? ❑ **Yes** ❑ **No**

Hospice:

Is the patient currently enrolled in hospice? ❑ **Yes** ❑ **No**

Does the provider confirm that the opioid is NOT used to manage symptoms associated with the patient's terminal condition or condition(s) related to the terminal illness? ❑ **Yes** ❑ **No**

Is the prescriber affiliated with the hospice provider? ❑ **Yes** ❑ **No**

If the prescriber is NOT affiliated with the hospice provider, does the prescriber attest coordination with the hospice provider confirming that the medication is unrelated to the terminal illness or related conditions? ❑ **Yes** ❑ **No**

Other Pain:

Is the patient in a long-term care facility (e.g., hospital or skilled nursing facility where patient is receiving skilled nursing care)? ❑ **Yes** ❑ **No**

Does the prescriber attest that in his/her clinical judgment, the requested opioid prescription filled after MAT (buprenorphine) therapy was dispensed is medically necessary? ❑ **Yes** ❑ **No**

Does the prescriber attest that either the buprenorphine or opioid drug interacting with each other will be discontinued? ❑ **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.