



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

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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: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic)	Strength:	Dosage Form:
<input type="checkbox"/> Check if request is for continuation of therapy	Directions for Use:	

Clinical Information (required)
Select the diagnosis below: <input type="checkbox"/> Cancer pain <input type="checkbox"/> Other pain. Please specify: _____ <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
Cancer Pain: Is the requested medication being used for the management of active cancer pain? <input type="checkbox"/> Yes <input type="checkbox"/> No
End of Life Care (Palliative Care): Is the patient on opioid pain medication for end of life (palliative) care? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hospice: Is the patient currently enrolled in hospice? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescriber affiliated with the hospice provider? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <u>unrelated</u> to the terminal illness or related conditions? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the prescriber attest that either the buprenorphine or opioid drug interacting with each other will be discontinued? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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