CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

Request for Opioid Treatment Prior Authorization Phone: 866-287-6156 / Fax 866-839-2372

This REQUEST is for: • Short-Acting Opioid • Long Acting Opioid • BOTH (check all that apply)

Member Information		**Provider Information**		
First Name:	Last Name:	Name:		
DOB:	Member ID:	NPI:	Specialty:	
Address:		Office Phone:		
City:	State:	Office Fax:		
Zip:	Phone:	Office Street Address:		
		City:	State:	Zip:

Medication Information		
Drug Name/Strength:		Directions for Usage:
Quantity:	Day Supply:	Diagnosis (ICD-10 Code):

Drug Name/Strength:		Directions for Usage:
Quantity:	Day Supply:	Diagnosis (ICD-10 Code):

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

Revised 4/15/2019

CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

Pain Assessment Please provide clinical

This program is funded in part by the Government
of the District of Columbia Department of Health Care Finance

CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

CareFirst Community Health Plan District of Columbia

ABARCA

Clinical Information PLEASE PROVIDE SUPPORTIVE DOCUMENTATION	
• YES • NO	Patient has a diagnosis of cancer-related pain and/or is actively undergoing cancer therapy. If yes, please indicate specific diagnosis: _____
• YES • NO	Patient has a diagnosis of terminal illness and is receiving palliative/end-of-life care. If yes, please indicate specific diagnosis: _____
• YES • NO	Patient has a diagnosis of sickle cell disease.
• YES • NO	Patient is currently receiving care at a long-term care facility
• YES • NO	Is the patient tolerant to opioid therapy? Note: Patients who are considered opioid tolerant are those who are taking at least 60 mg morphine/day, 25 mcg transdermal fentanyl/hour, or an equianalgesic dose of another opioid for at least a week.

Background Information PLEASE PROVIDE SUPPORTIVE DOCUMENTATION	
• YES • NO	Patient has had/will have random urine drug screens before and during treatment. → **Please provide laboratory documentation**
• YES • NO	Naloxone prescription was provided or offered to patient/patient's household
• YES • NO	Patient-prescriber pain management/opioid treatment agreement/contract signed and in medical record
• YES • NO	Prescriber has certified the benefits of opioid treatment for the patient outweigh the risks of treatment
• YES • NO	Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP)

DHCF The Department of Health Care Finance
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR
This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

CareFirst Community Health Plan District of Columbia

ABARCA

Short Acting Opioid Request For prescribed quantities exceeding 7 days	
All Request	
• **YES** • **NO**	Patient has a diagnosis of pain severe enough to require daily, around-the-clock, long-term opioid treatment. If yes, please indicate specific diagnosis: _____
• **YES** • **NO**	Patient has had an inadequate response to alternative treatment options such as non-opioid analgesics → **Please provide documentation to support previously failed therapies**
• **YES** • **NO**	Patient has contraindications to non-opioid analgesics (such as NSAID use in a patient with active ulcer condition/gastrointestinal bleeding/renal failure)
• **YES** • **NO**	Patient's active daily Morphine Equivalent Dose (MME) ≥ 90/day
• **YES** • **NO**	If **YES**, does the prescriber attested than he/she will be managing the patient's opioid therapy long term, reviewing federal regulations for opioid prescribing, has prescribed naloxone, and acknowledges warnings associated with the high opioid dosage?
Continuation of Therapy	
• **YES** • **NO**	Has patient displayed clinically meaningful improvements in pain and function without significant risk or harm?
• **YES** • **NO**	Patient has had a recent random urine drug screening → **Please provide laboratory documentation**
• **YES** • **NO**	Has been patient been assessed and shows no signs of opioid abuse disorder?
• **YES** • **NO**	Is there documentation demonstrating an appropriate upward titration?

DHCF The Department of Health Care Finance
WE ARE WASHINGTON DC
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

CareFirst Community Health Plan District of Columbia

ABARCA

Long Acting Opioid Request	
All Request	
• **YES** • **NO**	Patient has a diagnosis of pain severe enough to require daily, around-the-clock, long-term opioid treatment. If yes, please indicate specific diagnosis: _____
• **YES** • **NO**	Patient has had an inadequate response to alternative treatment options such as (but not limited to) non- opioid analgesics and immediate-release opioids → **Please provide documentation to support previously failed therapies**
• **YES** • **NO**	Patient has contraindications to non-opioid analgesics (such as NSAID use in a patient with active ulcer condition/gastrointestinal bleeding/renal failure)
• **YES** • **NO**	Patient's active daily Morphine Equivalent Dose (MME) ≥ 90/day
• **YES** • **NO**	Patient has one of the following conditions: • Significant respiratory depression • Acute/severe bronchial asthma or hypercarbia • Known/suspected paralytic ileus
Continuation of Therapy	
• **YES** • **NO**	Has patient displayed clinically meaningful improvements in pain and function without significant risk or harm?
• **YES** • **NO**	Patient has had a recent random urine drug screening →**Please provide laboratory documentation**
• **YES** • **NO**	Has been patient been assessed and shows no signs of opioid abuse disorder?
• **YES** • **NO**	Is there documentation demonstrating an appropriate upward titration?

DHCF The Department of Health Care Finance
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR
This program is funded in part by the Government of the District of Columbia Department of Health Care Finance