

## Drug Evaluation Request Form

**Complete this form and fax to:**  
**Fax #:** 1-800-956-2397  
**Urgent Request Only Fax:** 1-800-208-4050

**For Assistance Completing this form:**  
**Pharmacy Help Desk Fax:** 1-800-956-2397  
**Phone:** 1-800-499-1275

**Complete ALL the following Patient/Prescriber Information: (Please Print)**

Patient Information				
Patient Name:		Patient Phone #: (    )		
Patient ID #		Patient Birthdate:		
List Patient Allergy (If Any)				
Prescriber Information				
Prescriber Name:		Prescriber Specialty:		
Prescriber Address:				
Prescriber Phone #:		Prescriber Fax #:		
Prescriber NPI #:		Office Contact:		Extension:
Select one Medication/Medical and Provide Dispensing Information				
Medication (HCPCS)	Dose	Frequency	Weight (lbs. or kg)	Procedure Code
<b>Diagnosis/ICD-10:</b>				
Is this request for a: <input type="checkbox"/> New Start <b>OR</b> <input type="checkbox"/> Continuation of Therapy (recertification)? Start Date: _____				
Questions/Indications for Medical Necessity				
<b>** See the Medicare-Part D Formulary Level Cumulative Opioid Point of Sale Edits Policy (Medicare D-111) for full criteria @ <a href="#">Prescription Drug Policies   Providers   Excellus BlueCross BlueShield (excellusbcbs.com)</a> **</b>				
Current Opioid Prescriptions				
1. List all <b>current</b> opioids the patient is taking to treat pain?				
Drug Name	Strength & Dosing	Period of use		Outcomes
		Start:	End:	
		Start:	End:	
2. <b>Prescriber Attestation:</b> _____ The prescriber attests, ALL the opioids in the patient's treatment regimen listed above are necessary and appropriate				
Previous Opioid Therapy				
3. List all <b>previous</b> therapies the patient has attempted and their outcomes:				
Drug Name	Strength & Dosing	Period of use		Outcomes
		Start:	End:	
		Start:	End:	
4. Indicate the MME dose warranted to adequately manage the patient's pain. (For additional information on calculating the MME dose for a patient taking one or more opioid medications, please refer to: <a href="https://www.cdc.gov/opioids/providers/prescribing/pdf/calculating-total-daily-dose.pdf">https://www.cdc.gov/opioids/providers/prescribing/pdf/calculating-total-daily-dose.pdf</a> <b>OR</b> <a href="https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0">https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0</a> Online calculators/apps are also available to assist in calculating a total MME amount.				
(*NOTE: The accumulated MME amount you select below will be the new limit at which the patient's opioid prescription(s) will be subject to. The patient will require another coverage determination once they exceed the newly selected limit.)				
<b>Prescriber Attestation:</b>				
_____ The prescriber attests no maximum limit for accumulated MME per day be set for this patient				
_____ The prescriber attests this patient be limited to a maximum accumulated MME dose up to 1000 mg/day				
_____ The prescriber attests this patient be limited to a maximum accumulated MME dose of up to 800mg/day				
_____ The prescriber attests this patient be limited a maximum accumulated MME dose of _____mg/day				

\*Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 I certify the above is true and accurate to the best of my knowledge