



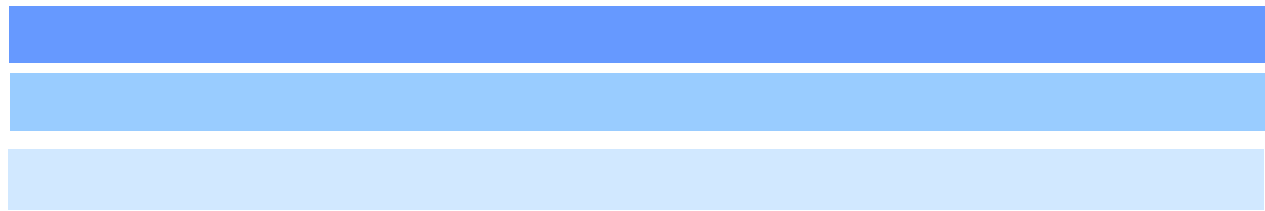
BlueCross BlueShield of Mississippi

It's good to be **Blue**.

How-to Guide

Opioid & Opioid
Combination
Medications
Medical Policy
Network Providers

Table of Contents



Introduction and Overview	Page 1
Short-Acting Opioid Guideline Scenarios	Page 3
Long-Acting Opioid Guideline Scenarios	Page 4
Clinical Best Practice Guidelines for Common Pain Conditions	Page 5
Opioid Prior Authorization Process	Page 12
Sample Supporting Documentation Forms	Page 20
Opioid Risk Tool	Page 21
Patient Agreement Forms	Page 23

Click on the items above for quick links to specific sections and tools.

How-to Guide for Opioid & Opioid Combination Medications Medical Policy

Our state and our nation are facing an epidemic of opioid misuse, addiction and overdose. This epidemic is an urgent health crisis resulting from many years of over prescribing and misunderstanding of the significant health risks these medications pose. In 2016, Blue Cross & Blue Shield of Mississippi (BCBSMS) partnered with our Network Providers including pain management experts, addiction experts and pharmacists to explore how we can do our part to address this public health crisis.

On March 1, 2017, BCBSMS is implementing the CDC Guideline for Prescribing Opioids for Chronic Pain through a comprehensive approach to ensure evidence-based, safe, responsible opioid prescribing for our members. This approach includes care management for those needing chronic pain management, enhanced patient education on the benefits and risks of taking opioids and a medical policy to reinforce safe prescribing. The goal is to provide medically necessary pain care, while reducing the risk of addiction and the unauthorized transfer of opioid prescriptions.

The Opioid and Opioid Combination Medications Medical Policy supports best practice treatment guidelines and includes limitations on drug usage and requires prior authorization as noted below:

Medication or Class	Policy
Short-acting Opioids	Coverage limited to 7-day supply of <50 MME/day for initial prescription. Coverage available for one additional 7-day supply within 60 days of initial fill.
Long-acting Opioids	Prior Authorization required for subsequent prescriptions. <i>(Excludes cancer patients and those receiving end-of-life care.)</i>
Opioids with Acetaminophen	Prior authorization required. <i>(Excludes cancer patients and those receiving end-of-life care.)</i>
	Limited to 3 grams/day of acetaminophen.

This How-to Guide is intended to provide Network Providers and their office staff with a practical overview of various patient scenarios. The guide includes instructions which outline the step-by-step process for efficiently submitting Opioid Prior Authorization requests, where required. The guide also includes roles and responsibilities that have been established for Network Providers and their patients to safely manage opioid prescriptions.

Roles and Responsibilities

Network Providers

- Follow the Opioid and Opioid Combination Medications Medical Policy Guidelines.
- Prescribe alternative treatments, where appropriate, based on best practice treatment guidelines.
- Educate the patient regarding the benefits and risks of taking opioid pain medication.
- When required, submit the required Prior Authorization form online via *myBlue* Provider.

- This prior authorization process will facilitate a healthy provider-patient conversation by requiring:
 - An active treatment plan that includes a specific treatment objective, duration of therapy and the use of other pharmacological and non-pharmacological agents for pain relief;
 - A patient-signed informed consent document ([see sample form](#));
 - An addiction risk assessment ([see sample form](#));
 - A written/signed agreement between provider and patient ([see sample form](#)) addressing issues of prescription management, diversion and the use of other substances including but not limited to benzodiazepines, alcohol and sedatives; and
 - Certification from the Network Provider that he or she is the single designated Network Provider, and a single designated Community PLUS Pharmacy has been agreed upon by the Provider and the patient.
- Monitor *my*Notifications to confirm status of the Prior Authorization.
- Monitor *my*Notifications to ensure timely submission of additional information if requested.
- Perform regular visits based on treatment plan agreed to with patient.

Patients

- Try alternative therapies as recommended by their Network Provider before taking opioids;
- Talk with their Network Provider about the risks of taking opioids and how to minimize the dangers;
- Safe, responsible prescribing of opioids based on CDC guidelines
 - Receiving no more than a 7-day supply of short-acting opioids with one 7-day refill, if needed.
 - Working with their Network Provider to complete our Opioid Prior Authorization process that serves as a practical guide to best-practice opioid prescribing when a long-acting opioid (or short-acting opioid beyond the quantity limit) is medically necessary.
- Agree to using one designated Network Provider and one designated Community PLUS Pharmacy location for opioid prescription fills.

When alternative treatment methods have failed and you prescribe an opioid for your patient, you may use the following chart to guide you in managing opioid prescriptions. Please refer to the following examples to help you and your office staff understand the practical approach for ensuring compliance with the Opioid and Opioid Combination Medications Medical Policy and any related prior authorizations.

SHORT ACTING OPIOIDS						
REQUIREMENTS BASED ON MEDICAL POLICY GUIDELINES						
Patient Scenario	Prior Approval Required	Quantity Limit	Refill Allowed	Treatment Plan	Informed Consent & Substance Use Disorder Assessment	Certification from Provider for Single Prescriber and Single Community Plus Pharmacy
Patient has a Cancer Diagnosis	NO	NO	YES	May be in Case Management	NO	NO
Patient is in Hospice/ End-of-Life Care	NO	NO	YES	May be in Case Management	NO	NO
Patient needs initial supply of < 50 morphine milligram equivalents (MME)* *Refer to best practice guidelines	NO	7 days	YES: One additional 7 day supply, if within 60 days of the original prescription.	NO	NO	NO
	After maximum of 14-day supply, Prior Approval is required.			YES	YES	YES
Patient needs continued short-acting opioid prescription for a chronic condition with >6 months usage	NO*	NO*	YES: One additional 7 day supply, if within 60 days of the original prescription.	NO	NO	NO
	*Prior Approval required beginning June 1, 2017.			YES	YES	YES
Patient has been using a short-acting opioid for >6 months and needs continued short-acting opioid prescription for diagnosis of pain or opioid dependence	NO*	NO*	YES: One additional 7 day supply, if within 60 days of the original prescription.	NO	NO	NO
	*Prior Approval required beginning April 1, 2017.			YES	YES	YES
Patient has been using a short-acting opioid for >6 months and needs continued short-acting opioid prescription for a diagnosis other than chronic or pain or opioid dependence	NO	7 days	YES: One additional 7 day supply, if within 60 days of the original prescription.	NO	NO	NO
	After maximum of 14-day supply, Prior Approval is required.			YES	YES	YES
Patient needs continued short-acting opioid prescription for any condition with <6 months usage	NO	7 days	YES: One additional 7 day supply, if within 60 days of the original prescription.	NO	NO	NO
	After maximum of 14-day supply, Prior Approval is required.			YES	YES	YES

For the purpose of this medical policy, chronic is defined as a diagnosis of migraine, fibromyalgia, osteoarthritis, low back/neck pain and neuropathic pain. The pain and opioid dependence transition period is determined based on the diagnosis on the claim.

LONG ACTING (EXTENDED RELEASE) OPIOIDS							
REQUIREMENTS BASED ON MEDICAL POLICY GUIDELINES							
Patient Scenario	Prior Approval	Quantity Limit	Refill Allowed	Documented Treatment Failure with Short Acting Opioid in Past 60 Days	Treatment Plan	Informed Consent & Substance Use Disorder Assessment	Certification from Provider for Single Prescriber and Single Community Plus Pharmacy Agreed on with Patient
Patient has a Cancer Diagnosis	NO	NO	YES	NO	May be in Case Management	NO	NO
Patient is in Hospice/ End of Life Care	NO	NO	YES	NO	May be in Case Management	NO	NO
Patient needs initial prescription for long-acting opioid* *Refer to best practice guidelines for common pain conditions	Prior Approval required beginning March 1, 2017.			YES	YES	YES	YES
Patient needs continued long-acting opioid prescription for a condition other than chronic condition	Prior Approval required beginning April 1, 2017.			YES	YES	YES	YES
Patient needs continued long-acting opioid prescription for a chronic condition	Prior Approval required beginning June 1, 2017.			YES	YES	YES	YES

For the purpose of this medical policy, chronic is defined as a diagnosis of migraine, fibromyalgia, osteoarthritis, low back/neck pain and neuropathic pain.

The following pages of this guide contain additional resources to assist you:

- Clinical Best Practice Guidelines for Common Pain Conditions
- Opioid Prior Authorization Process
- Sample Supporting Documentation Forms
 - o Opioid Risk Tool
 - o Patient Agreement Forms



Clinical Best Practice Guidelines for Common Pain Conditions

DESCRIPTION

All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment. This document provides evidence-based clinical best practice guidelines for management of common pain conditions.

Pain should be assessed and its cause diagnosed as clearly as possible using history and physical examination and appropriate testing. The medical management of pain should consider current clinical knowledge and medical research and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the Provider. Pain should be promptly treated with non-pharmacologic therapy and non-opioid pharmacologic therapy, without acceptable results before opioids are considered.

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release/short-acting opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than 7 days will rarely be needed. In addition, opioids are not the first-line therapy for chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Evidence suggests that non-opioid treatments, including non-opioid medications and non-pharmacological therapies can provide relief to those suffering from chronic pain, and are safer.

Evidence-based clinical decision support is provided for the following **acute** pain conditions:

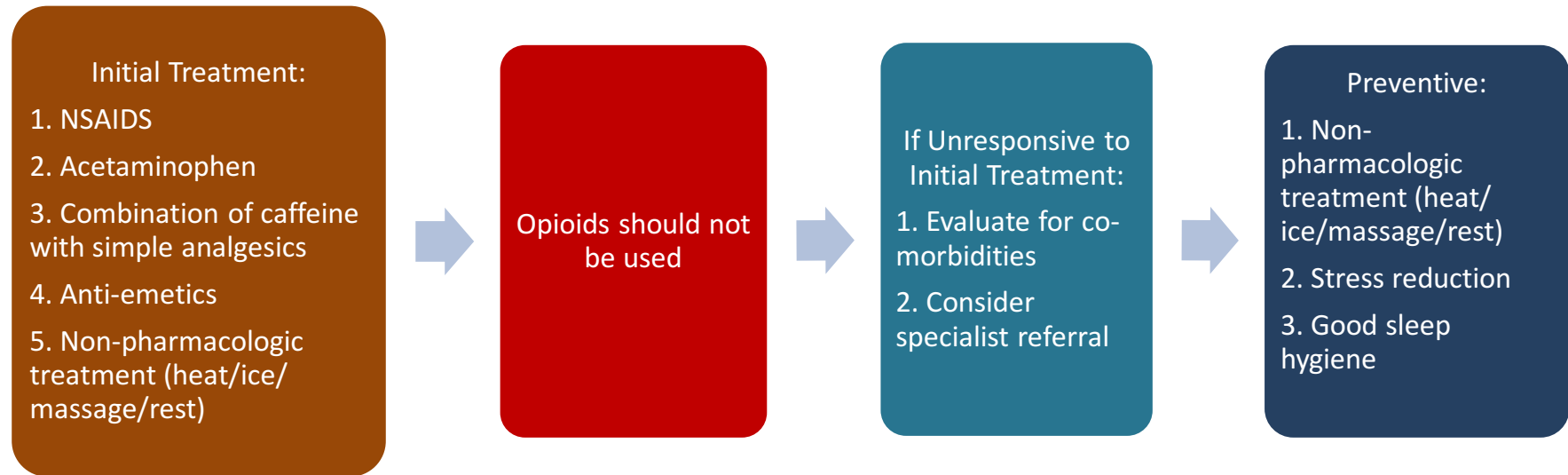
1. Headache
2. Back/Neck Pain Due to Strain or Sprain (Non-Radicular)
3. Mild-to-Moderate Radicular Back/Neck Pain
4. Severe Radicular Back/Neck Pain

Evidence-based clinical decision support is provided for the following **chronic** pain conditions:

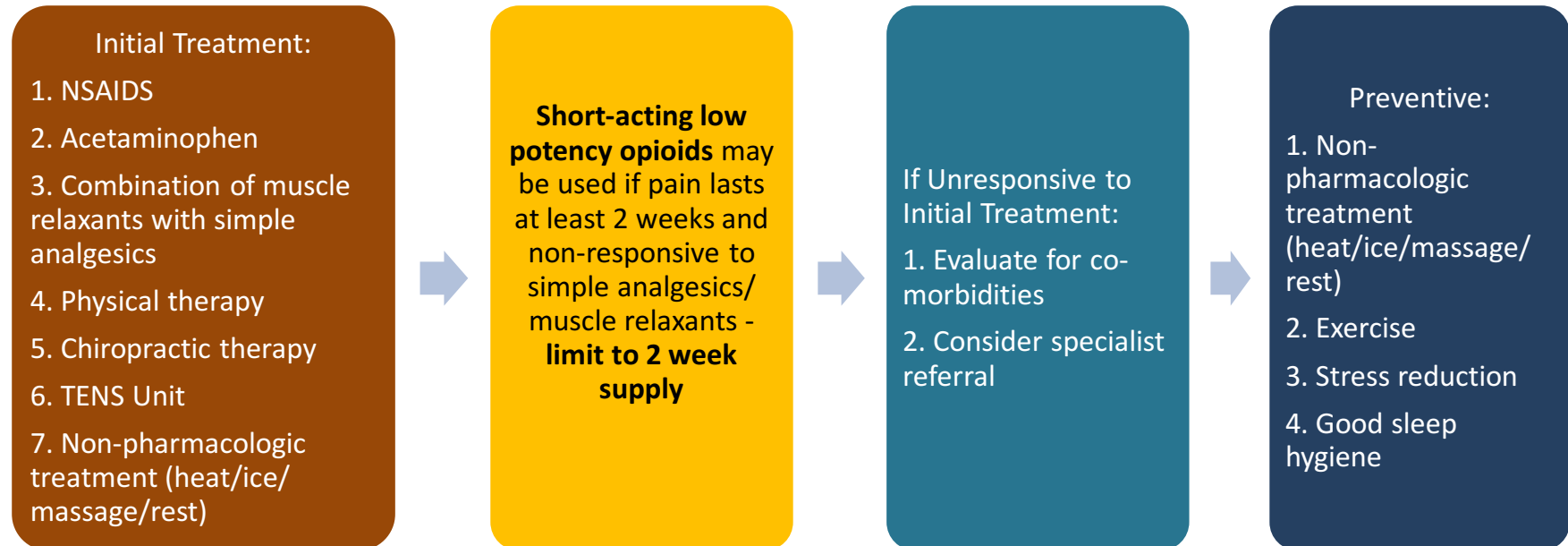
1. Migraine (Vascular Headaches)
2. Osteoarthritis
3. Fibromyalgia
4. Carpel Tunnel Syndrome (Neuropathic Pain)

CLINICAL BEST PRACTICE GUIDELINES FOR COMMON ACUTE PAIN CONDITIONS

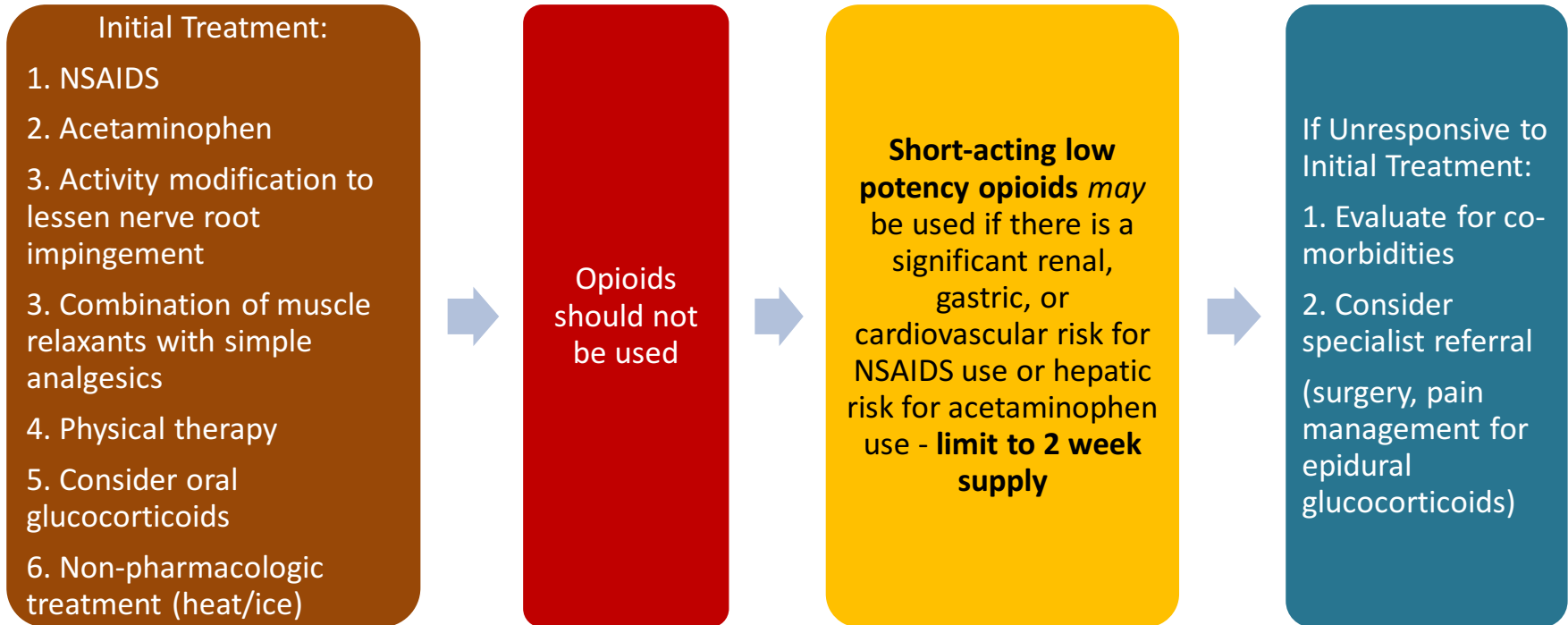
Headache



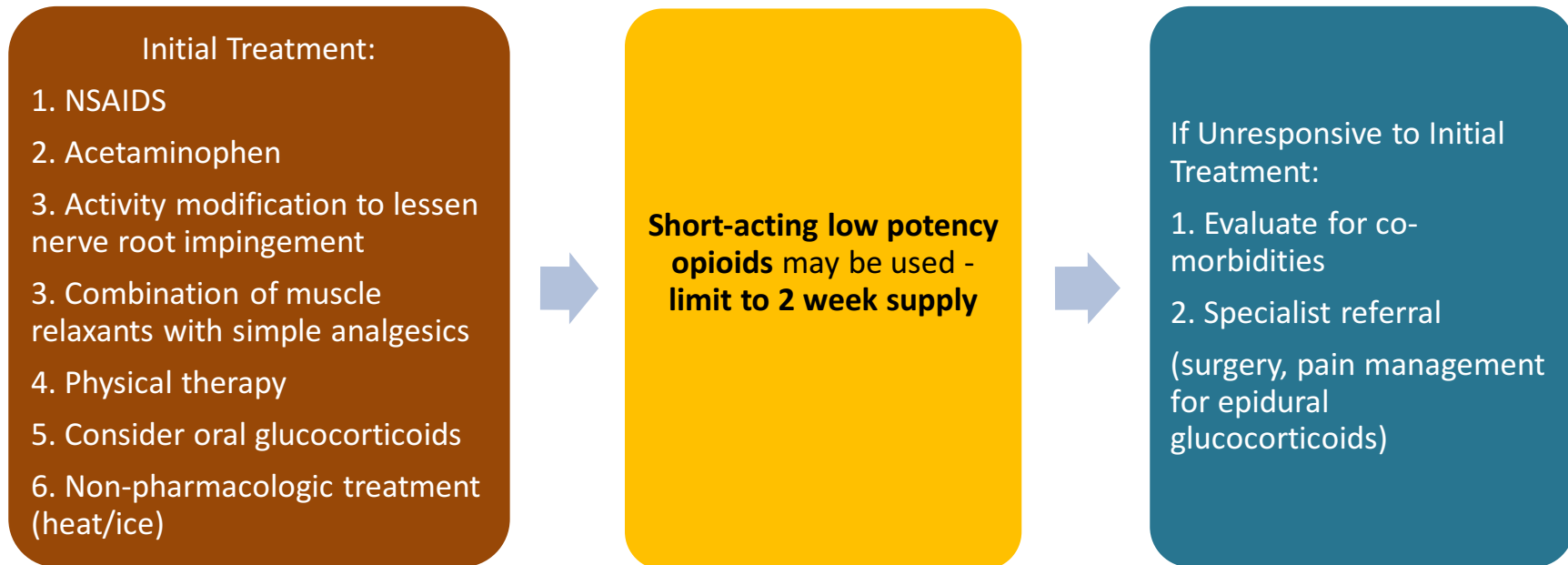
Back/Neck Pain Due to Strain or Sprain (Non-Radicular)



Mild-to-Moderate Radicular Back/Neck Pain (Pain Rating of 1-6/10 on Universal Pain Assessment Tool)

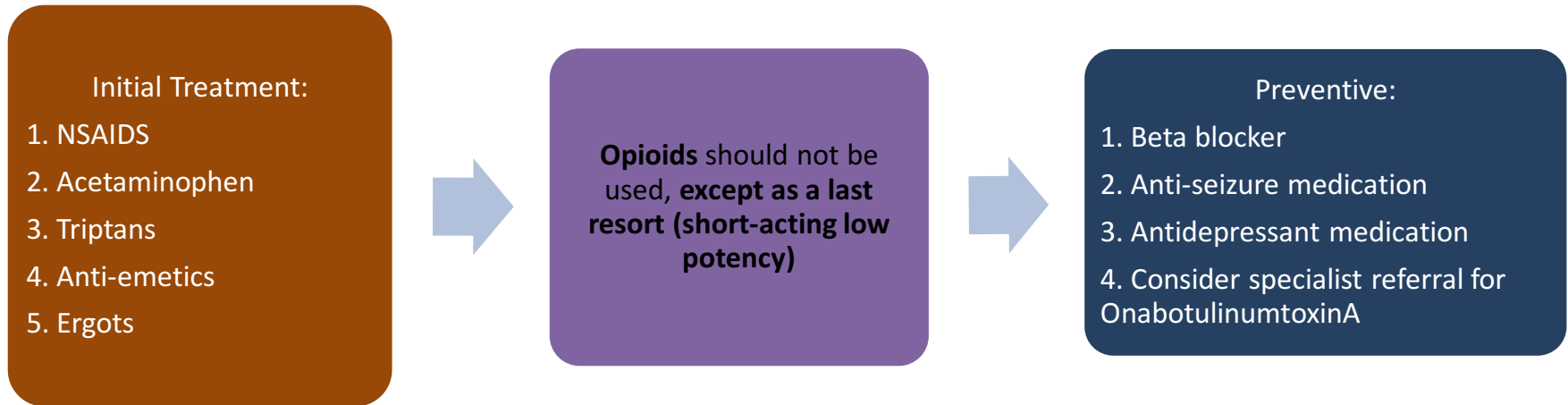


Severe Radicular Back/Neck Pain (Pain Rating of 7-10/10 on Universal Pain Assessment Tool))

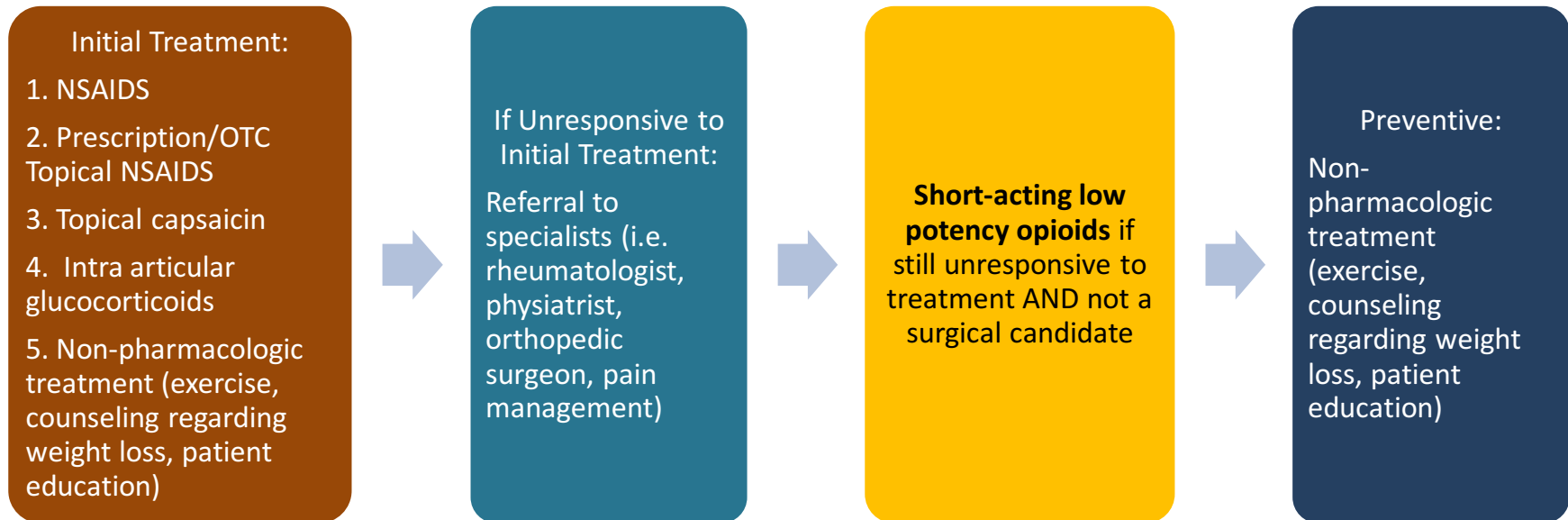


CLINICAL BEST PRACTICE GUIDELINES FOR COMMON CHRONIC PAIN CONDITIONS

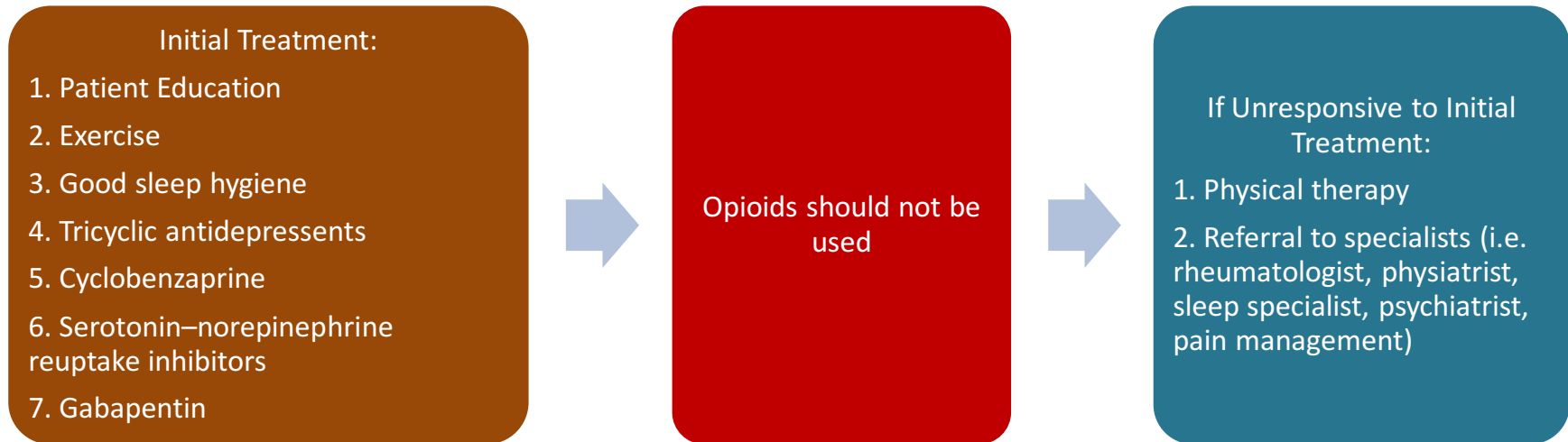
Migraine



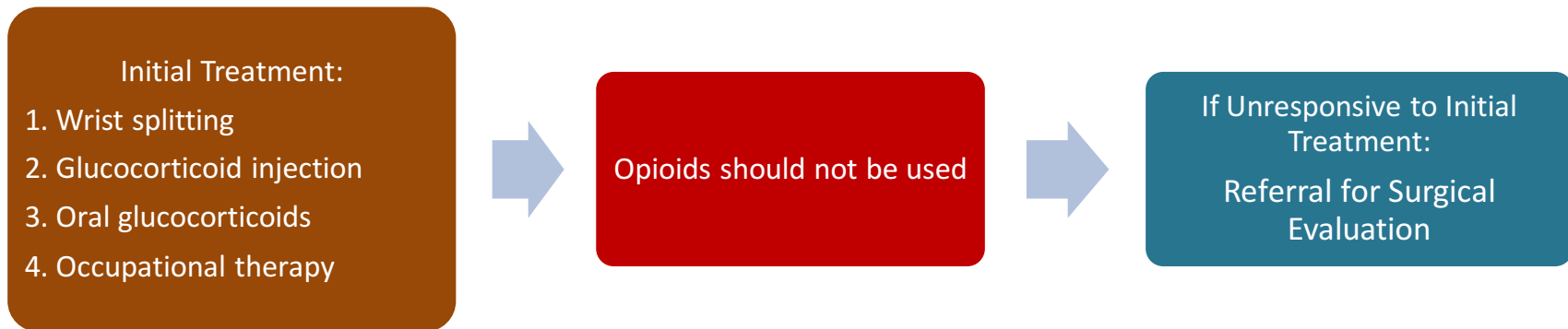
Osteoarthritis



Fibromyalgia



Carpel Tunnel Syndrome (Neuropathic Pain)



POLICY HISTORY

02/20/2017: Guidelines approved by Pain Management Physician Advisory Committee

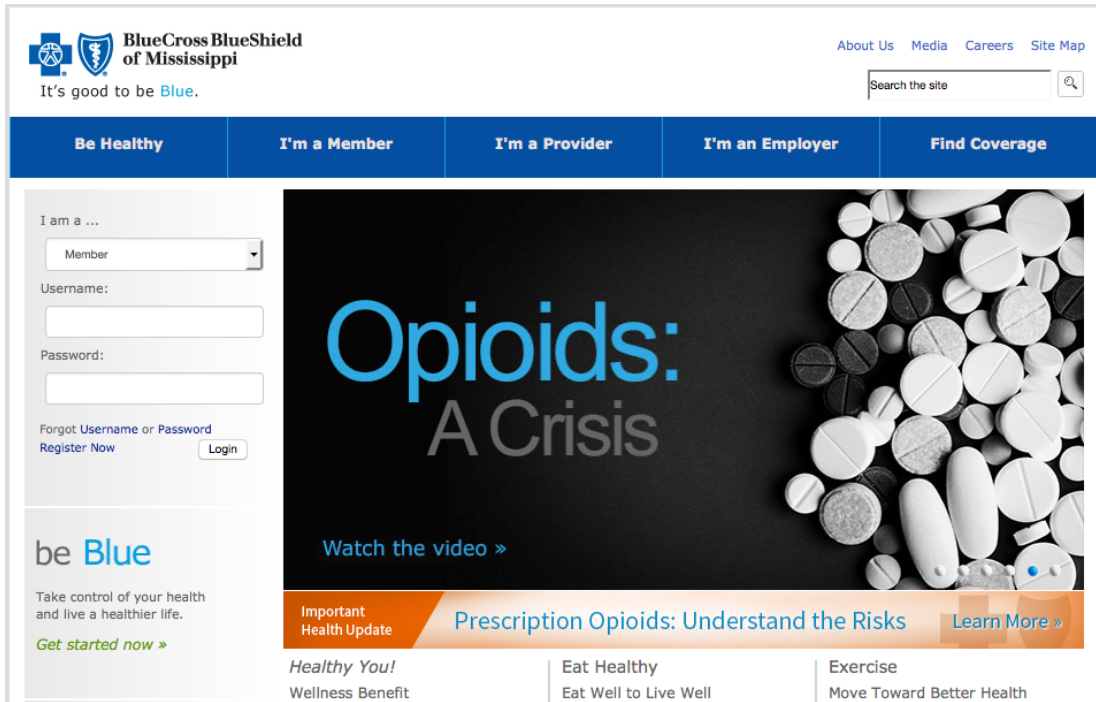
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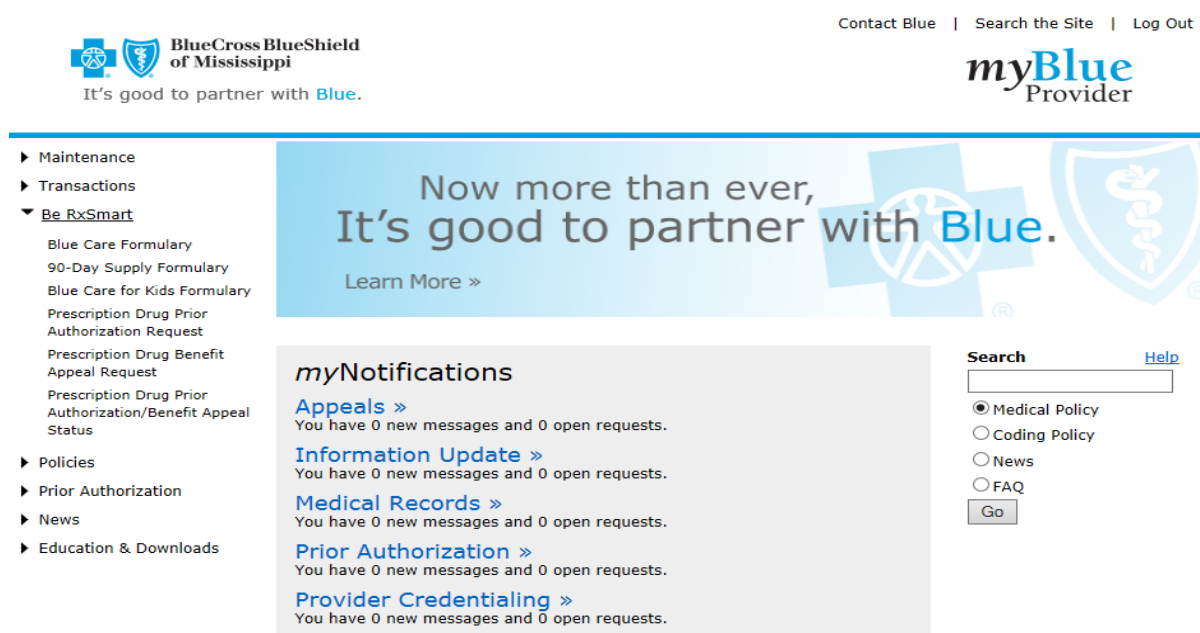
To assist your staff in completing the electronic prior authorization process for opioid medication, the step-by-step guide to the prior authorization process is shown below.

Opioid Prior Authorization Process for a Network Provider

1. Begin the electronic prior authorization request by logging onto *myBlue* Provider at www.bcbsms.com.



2. Click the Be RxSmart dropdown and choose “Prescription Drug Prior Authorization Request” from the list of options.



3. Next you will be prompted to type in the BCBSMS Member ID and Prescribing Provider NPI. Once you enter the Member ID, select "Get Member Info." **You must click the dropdown arrow to ensure you select the correct patient name if there are multiple patients listed on the benefit plan.**

Enter the Prescribing NPI and select "Get Provider Info," then click the dropdown to review the provider information.

Prescription Drug Prior Authorization Request

Start a new request by clicking the Start New Request button. Once you have completed and submitted the request, you can check the status of the request by clicking on the Prescription Drug Prior Authorization Status on the home page. You can start the process by providing the following required information.

BCBSMS Member ID <input type="text"/>	<input type="button" value="Get Member Info >>"/>	Choose a Member <input type="text"/>
Prescribing NPI <input type="text"/>	<input type="button" value="Get Provider Info >>"/>	Choose a Provider <input type="text"/>

4. The patient's information will automatically populate once the patient is selected.

Prescription Drug Prior Authorization Request

Start a new request by clicking the Start New Request button. Once you have completed and submitted the request, you can check the status of the request by clicking on the Prescription Drug Prior Authorization Status on the home page. You can start the process by providing the following required information.

BCBSMS Member ID <input type="text"/>	<input type="button" value="Get Member Info >>"/>	Choose a Member <input type="text"/>
Prescribing NPI <input type="text"/>	<input type="button" value="Get Provider Info >>"/>	Choose a Provider <input type="text"/>

5. The next step will be to select the drug name for the prescription the patient will be receiving.

Prescription Drug Prior Authorization Request

Start a new request by clicking the Start New Request button. Once you have completed and submitted the request, you can check the status of the request by clicking on the Prescription Drug Prior Authorization Status on the home page. You can start the process by providing the following required information.

BCBSMS Member ID [Get Member Info >>](#) **Choose a Member**

Prescribing NPI [Get Provider Info >>](#) **Choose a Provider**

Step 1: Find a Medication

Enter drug name, or partial drug name, and click Search to find the matching medication(s) requiring prior authorization.

Drug Name: [Search](#)

Step 2: Select a Prior Authorization Request Form

Your selection "OXYCODONE HCL ER" returned the following prescription drugs.

Double-click a drug to open a Prior Authorization Request form.

Drug Name	Copay Category	Medical Condition
OXYCODONE HCL ER	4	Opioid and Opioid Combinations
OXYCONTIN	4	Non-DSP Prior Authorization

[Cancel Prior Authorization Request](#)

6. Once the drug name has been selected, the next page will include Patient Information, Coverage Information, Prescriber Information and Guiding Documentation/Instructions. There are fields that are auto-populated based on the Patient and Prescriber. All of the questions must be thoroughly answered to ensure the medical information is properly documented. The Opioid and Opioid Combinations section requires you to enter information on the diagnosis, medical justification and prescription. Additional information can be placed in the Additional Explanation field.

Patient Information

Name	<input type="text"/>		
Home Phone	<input type="text"/>	Alternate Phone	<input type="text"/>
Address	<input type="text"/>		
City	<input type="text" value="PEARL"/>	State	<input type="text" value="MS"/> <input type="text" value="39208"/>
	<input checked="" type="radio"/> Male <input type="radio"/> Female	Date of Birth	<input type="text"/>
Alternate Contact	<input type="text"/>	Relationship	<input type="text"/>
Home Phone	<input type="text"/>	Alternate Phone	<input type="text"/>

Coverage Information

Primary Insurance	<input type="text" value="BCBS of MS"/>	Secondary Insurance	<input type="text"/>
Identification Number	<input type="text"/>	Identification Number	<input type="text"/>
Subscriber Name	<input type="text"/>	Subscriber Name	<input type="text"/>
Relationship to Patient	<input type="text" value="BCBS of MS"/>	Relationship to Patient	<input type="text"/>

Prescriber Information

Prescriber Name	<input type="text"/>	Office Contact Name	<input type="text"/>
Phone	<input type="text"/>	Fax	<input type="text"/>
Mailing Address	<input type="text"/>		
City	<input type="text" value="HATTIESBURG"/>	State	<input type="text" value="MS"/> <input type="text" value="39401"/>
Physical Address	<input type="text"/>		
City	<input type="text"/>	State	<input type="text" value="MS"/> <input type="text"/>
E-mail Address	<input type="text"/>	DEA Number	<input type="text"/>
NPI	<input type="text"/>		

Opioid and Opioid Combinations

Primary ICD

Secondary ICD

Medical Justification for Initiation or Continuation of therapy:

The following required supporting documentation is attached:

- An active treatment plan that includes a specific treatment objective, duration of therapy, and the use of other pharmacological and non-pharmacological agents for pain relief.
- An informed consent document signed by the patient
- A substance use disorder risk assessment.*
- A signed agreement between prescriber and patient addressing issues of prescription management, diversion and the use of other substances
- Provider certification that he/she is the single Company designated Network Provider and a single Company designated Community PLUS Pharmacy has been agreed upon by the Provider and the patient.

Failure to upload or fax required supporting documentaiton will result in denial of the request.

***A Risk assessment is attached to the Opioid and Opioid Combination Medications medical policy, if needed.**

Prescription Type: New Start Continued Tx

Medication Requested:

OXYCODONE HCL ER

Dose:

Sig:

Quantity:

Expected Duration of Therapy:

Community PLUS Pharmacy Name:

Address City State Zip Code

If the request is for an extended release/long-acting opioid medication, list all immediate/short-acting opioid drug failures and time of the therapy.

I certify that this therapy is necessary for this patient, and I will be supervising the patient's treatment accordingly. I acknowledge by signing this form that the information contained within is correct, and I also acknowledge that my records are subject to audit by Blue Cross & Blue Shield of Mississippi.

Prescriber Signature

Date

Additional Explanation

If you need to provide additional explanation for any field above, please use the space below.

Some of the questions will require additional documentation to complete the prior authorization request. Documentation can be submitted through document upload or faxed once the Opioid Prior Authorization form has been submitted.

7. Once all of the information has been entered, a confirmation message will be displayed that presents options to upload more information or to print the fax cover sheet if supplemental documentation will be faxed.

Prescription Drug Information Received

Your request has been received by Blue Cross & Blue Shield of Mississippi. You can check the status of your request by clicking on the myNotifications section on the home page.

To submit attachments needed to accompany this request, click [here](#).

To print a cover sheet in order to fax attachments needed to accompany this request, click [here](#).

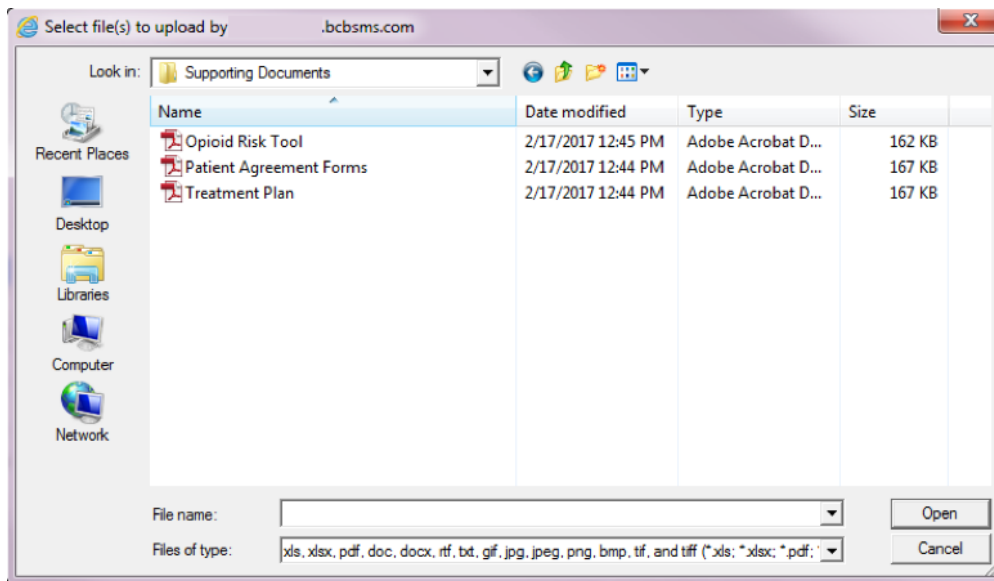
To submit another Prescription Drug Prior Authorization request, please click [here](#).

If the “submit attachments needed to accompany this request” option is selected, the following box will display:

Upload Additional Documentation Instructions

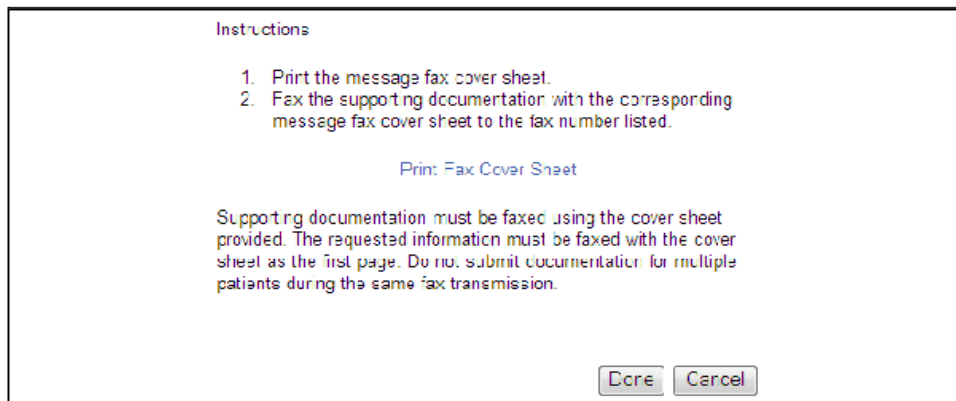
1. Click the 'Browse' button to browse your system for the file.
 - a. Select the file to upload.
 - b. Click the 'Open' button to upload the file.
2. Click the 'Done' button when all files have been uploaded.

First, Choose the Upload option. Second, click the “Browse” button to select the corresponding file that will be uploaded.





Once the corresponding file has been selected, click the 'Open' button to return to the upload box. This will save the document to that

If the “print a cover sheet in order to fax attachments needed to accompany this request” option is selected, this box will appear:



Click on the “Print Fax Cover Sheet” option to upload the fax cover sheet. The fax cover sheet has a bar code that identifies the specified prior authorization request; therefore, it is unique to the request and **MUST be attached to the documentation as the first page of the fax** for the information to be processed correctly. If the fax cover sheet is not the first page transmitted, the information will not be processed.

The following is an example of an “Electronic Pre-Certification/Prior Authorization” fax cover sheet:

123456789M	
	Blue Cross BlueShield of Mississippi
Committed to a Healthier Mississippi.	
SMITH	
Electronic Pre-Certification/Prior Authorization Fax Cover Sheet	
ATTENTION: BLUE CROSS & BLUE SHIELD OF MISSISSIPPI	
FROM:	
SUBSCRIBER ID:	TAX ID:
PATIENT FIRST NAME:	PATIENT LAST NAME:
CLAIM NUMBER:	REQUEST ID: 4593
For this documentation to be processed in a timely and accurate manner, please follow these instructions:	
<ol style="list-style-type: none"> 1) Print this Page. 2) Place this sheet on top of the requested information for the specific patient above. 3) Fax this cover sheet with requested information for the specific patient above to 601-664-5205. 	
Failure to follow these instructions may result in a delay in processing.	
<ol style="list-style-type: none"> 1) Medical documentation submitted under this fax cover sheet <u>must</u> be applicable to the specific patient above. 2) Only this fax cover sheet may be used for faxing the requested information for this patient. 	
Confidentiality and Privacy Notice	
<small>The information contained in this message, and attachments hereto, is confidential and it may be subject to attorney/client privilege or the attorney work product doctrine, and may contain Protected Health Information that is subject to use and disclosure restrictions under federal law. It is intended only for the use of the individual or entity named above. If the recipient or reader of this message is not the intended recipient, or the employee or agent responsible to deliver this message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this message is strictly prohibited. If you have received this message in error, please notify us immediately so that we may arrange for the return of the original material. All recipients are expected to maintain appropriate protections on the information contained herein.</small>	
<small>BCBS 24766 Rev. 12/11</small>	<small>Blue Cross & Blue Shield of Mississippi, A Mutual Insurance Company, is an independent licensee of the Blue Cross and Blue Shield Association.</small>
 M S G 4 5 0 3	

Once the prior authorization and supporting documentation have been submitted it is important to monitor *my*Notifications daily for additional correspondence and for prior authorization determination from the BCBSMS.

All communication regarding the status of the prior authorization will be handled via *my*Notifications. It is very important that you check *my*Notifications daily to determine if your request was approved, denied, or if additional information is requested. The notifications will have additional notes explaining the decision that was made. Please read these notes carefully to ensure any additional documentation requested is submitted to properly process the prior authorization request.

Your *myNotifications* requests will appear under the “Prior Authorization” header in the *myNotifications* box.

BlueCross BlueShield of Mississippi
It's good to partner with Blue.

Contact Blue | Search the Site | Log Out

myBlue Provider

myBlue member app
Secure, personalized access to your claims and benefit information on your mobile device!

Learn More »

myNotifications

- Appeals »
You have 0 new messages and 0 open requests.
- Medical Records »
You have 0 new messages and 0 open requests.
- Prior Authorization »**
You have 0 new messages and 0 open requests.
- Provider Credentialing »
You have 0 new messages and 0 open requests.

Search [Help](#)

Go

- Medical Policy
- Coding Policy
- News
- FAQ

You will be able to review your new and open requests once you click on the “Prior Authorization” link.

If assistance is needed with completing a prior authorization, the Network Provider’s office should contact us via [Contact Blue](#).

Below, you will find the following sample supporting documents:

- [Opioid Risk Tool](#)
- [Sample Patient Agreement Forms](#) - The sample forms attached here contain language that makes these agreements meet both of the following prior authorization criteria:
 - A patient-signed informed consent document
 - A written/signed agreement between provider and patient addressing issues of prescription management, diversion and the use of other substances including but not limited to benzodiazepines, alcohol and sedatives

These forms can be used to assist you in your conversations and assessments with your patients. Completed forms may be submitted as the supporting documents for the prior authorization.

Opioid Risk Tool

Introduction

The Opioid Risk Tool (ORT) is a brief, self-report screening tool designed for use with adult patients in primary care settings to assess risk for opioid abuse among individuals prescribed opioids for treatment of chronic pain. Patients categorized as high-risk are at increased likelihood of future abusive drug-related behavior. The ORT can be administered and scored in less than 1 minute and has been validated in both male and female patients, but not in non-pain populations.

Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk tool. *Pain Med.* 2005; 6 (6) : 432

Sample Patient Agreement Forms

Introduction

This resource includes two sample patient agreement forms that can be used with patients who are beginning long-term treatment with opioid analgesics or other controlled substances. These documents contain statements to help ensure patients understand their role and responsibilities regarding their treatment (e.g., how to obtain refills, conditions of medication use), the conditions under which their treatment may be terminated, and the responsibilities of the health care provider. These documents can help facilitate communication between patients and healthcare providers and resolve any questions or concerns before initiation of long-term treatment with a controlled substance.

Pain Treatment with Opioid Medications: Patient Agreement*

I, _____, understand and voluntarily agree that
(initial each statement after reviewing):

_____ I will keep (and be on time for) all my scheduled appointments with the doctor and other members of the treatment team.

_____ I will participate in all other types of treatment that I am asked to participate in.

_____ I will keep the medicine safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment, and may not be replaced at all.

_____ I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of the treatment team.

_____ I will not call between appointments, or at night or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.

_____ I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.

_____ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____ I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

_____ I will sign a release form to let the doctor speak to all other doctors or providers that I see.

_____ I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medicine.

_____ I will use only one pharmacy to get all on my medicines: _____
Pharmacy name/phone#

_____ I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (klonopin, xanax, valium) or stimulants (ritalin, amphetamine) without telling a member of the treatment team **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

*Adapted from the American Academy of Pain Medicine
<http://www.painmed.org/Workarea/DownloadAsset.aspx?id=3203>

Patient Agreement Form

Patient Name:

Medical Record Number:

Addressograph Stamp:

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of _____ (print names of medication(s)) may cause addiction and is only one part of the treatment for: _____ (print name of condition—e.g., pain, anxiety, etc.).

The goals of this medicine are:

- to improve my ability to work and function at home.
- to help my _____ (print name of condition—e.g., pain, anxiety, etc.) as much as possible without causing dangerous side effects.

I have been told that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do it slowly or I may get very sick.

I agree to the following:

- I am responsible for my medicines. I will not share, sell, or trade my medicine. I will not take anyone else's medicine.
- I will not increase my medicine until I speak with my doctor or nurse.
- My medicine may not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all appointments set up by my doctor (e.g., primary care, physical therapy, mental health, substance abuse treatment, pain management)
- I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
- I agree to give a blood or urine sample, if asked, to test for drug use.

Refills

Refills will be made only during regular office hours—Monday through Friday, 8:00AM-4:30 PM. No refills on nights, holidays, or weekends. I must call at least three (3) working days ahead (M-F) to ask for a refill of my medicine. **No exceptions will be made.** I will not come to Primary Care for my refill until I am called by the nurse.

I must keep track of my medications. No early or emergency refills may be made.

Pharmacy

I will only use one pharmacy to get my medicine. My doctor may talk with the pharmacist about my medicines.

The name of my pharmacy is _____.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medicine (for example, a dentist, a doctor from the Emergency Room or another hospital, etc.) I must bring this medicine to Primary Care in the original bottle, even if there are no pills left.

Privacy

While I am taking this medicine, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medicine. I will be asked to sign a release at that time.

Termination of Agreement

If I break any of the rules, or if my doctor decides that this medicine is hurting me more than helping me, this medicine may be stopped by my doctor in a safe way.

I have talked about this agreement with my doctor and I understand the above rules.

Provider Responsibilities

As your doctor, I agree to perform regular checks to see how well the medicine is working.

I agree to provide primary care for you even if you are no longer getting controlled medicines from me.

Patient's signature

Date

Resident Physician's signature

Attending Physician's signature

- This document has been discussed with and signed by the physician and patient. (A signed copy stamped with patient's card should be sent to the medical records department and a copy given to the patient.)