



**MANAGED HEALTHCARE NORTHWEST, INC.**

422 E. BURNSIDE, SUITE 215, PO BOX 4629, PORTLAND, OREGON 97208-4629  
(503) 413-5800 FAX (503) 413-5864

**CAREMARK COMP  
PRECERTIFICATION REQUEST FORM  
FOR INCREASING OPIOID DOSAGE  
ABOVE 120 MG MED/DAY**

Date: \_\_\_\_\_

Worker Name: \_\_\_\_\_ Claim #: \_\_\_\_\_

**NOTE: You are required to refer the worker for an evaluation with one of the five designated pain specialists. Please complete the attached Opioid Pain Evaluation Referral Form and send it to the office of the pain specialist you select. The office will schedule your patient for an evaluation and send their report to you. If you wish to increase the patient's opioid dosage after reviewing the report, complete this form and send to Caremark Comp with all required documentation.**

Ordering Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Condition(s) being treated: \_\_\_\_\_

Medication	Dose	Drug(s) Requested			
		Frequency	Medication	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Does the request represent an increase in the opioid dose?  Yes  No

Please include the following documentation:

1. Opioid Risk Assessment
2. Urine Drug Analysis  
(CCLAO – CareMark Comp LAO Panel)
3. Medication Agreement (signed by worker)
4. VAS/Functional Assessment
5. Material Risk Notice (signed by worker)
6. Opioid Pain Evaluation Referral Report



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## CAREMARK COMP OPIOID RISK ASSESSMENT

Date: \_\_\_\_\_

Worker Name: \_\_\_\_\_ Claim #: \_\_\_\_\_

		Mark Each Box That Applies	Item Score if Female	Item Score if Male
<b>Family History of Substance Abuse</b>	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
<b>Personal History of Substance Abuse</b>	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
<b>Age</b> (mark box if 16-45)		[ ]	1	1
<b>History of Preadolescent Sexual Abuse</b>		[ ]	3	0
<b>Psychological Disease</b>	If any of these apply: Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
	TOTAL _____			

### Total Score Risk Category

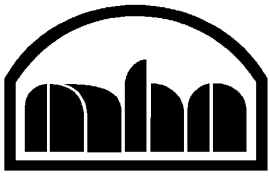
Low Risk 0-3

Moderate Risk 4-7

High Risk  $\geq$  8

Physician/Provider Name: \_\_\_\_\_  
(Please Print)

Signature: \_\_\_\_\_



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**CAREMARK COMP  
 MEDICATION AGREEMENT**

Worker Name: \_\_\_\_\_

Claim #: \_\_\_\_\_

**Opioid (narcotic) treatment for chronic pain is used to reduce pain and improve what you are able to do each day.**

Along with opioid treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic analgesics, physical therapy, psychological counseling or other therapies or treatment. Vocational counseling may be provided to assist in your return to work effort.

I, \_\_\_\_\_, understand that compliance with the following guidelines is important in continuing pain treatment with Dr. \_\_\_\_\_.

**1. I understand that I have the following responsibilities:**

- a. I will take medications only at the dose and frequency prescribed.
- b. I will not increase or change medications without the approval of this provider.
- c. I will actively participate in Return to Work (RTW) efforts and in any program designed to improve function (including social, physical, psychological and daily or work activities).
- d. I will not request opioids or any other pain medicine from providers other than from this one. This provider will approve or prescribe all other mind and mood altering drugs.
- e. I will inform this provider of all other medications that I am taking.
- f. I will obtain all medications from one pharmacy, when possible. By signing this agreement, I give consent to this provider to talk with the pharmacist.
- g. I will protect my prescriptions and medications. Only one lost prescription or medication will be replaced in a single calendar year. I will keep all medications from children.
- h. I agree to participate in psychiatric or psychological assessments, if necessary.
- i. If I have an addiction problem, I will not use illegal or street drugs or alcohol. This provider may ask me to follow through with a program to address this issue. Such programs may include the following:
  - 12-step program and securing a sponsor
  - Individual counseling
  - Inpatient or outpatient treatment
  - Other: \_\_\_\_\_

**2. I understand that in the event of an emergency,** this provider should be contacted and the problem will be discussed with the emergency room or other treating provider. I am responsible for signing a consent to request record transfer to this doctor. No more than 3 days of medications may be prescribed by the emergency room or other provider without this provider's approval.

**3. I understand that I will consent to random drug screening.** A drug screen is a laboratory test in which a sample of my urine or blood is checked to see what drugs I have been taking.

**4. I will keep my scheduled appointments and/or cancel my appointment a minimum of 24 hours prior to the appointment.**

**5. I understand that this provider may stop prescribing opioids or change the treatment plan if:**

- a. I do not show any improvement in pain from opioids or my physical activity has not improved.
- b. My behavior is inconsistent with the responsibilities outlined in #1 above.
- c. I give, sell or misuse the opioid medications.
- d. I develop rapid tolerance or loss of improvement from the treatment.
- e. I obtain opioids from other than this provider.
- f. I refuse to cooperate when asked to get a drug screen.
- g. If an addiction problem is identified as a result of prescribed treatment or any other addictive substance.
- h. If I am unable to keep follow-up appointments.

<p><b>Worker Signature</b> _____</p> <p style="text-align: right;"><b>Date</b> _____</p>	<p><b>Physician/Provider Name</b> _____          (Please Print)</p> <p><b>Signature</b> _____</p> <p style="text-align: right;"><b>Date</b> _____</p>
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Provider: Must renew Agreement every 6 months.

Reference: Washington State Dept of Labor & Industries



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**CAREMARK COMP  
MATERIAL RISK NOTICE**

Date: \_\_\_\_\_

Worker Name: \_\_\_\_\_ Claim #: \_\_\_\_\_

This will confirm that you have been diagnosed with \_\_\_\_\_,  
a condition causing your intractable pain.

I have recommended treating your condition with the following Opioid (narcotic) pain medications.  
(These are controlled substances)

\_\_\_\_\_

In addition to significant reduction in your pain, your personal goals from therapy are:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Alternatives to this therapy are: \_\_\_\_\_

\_\_\_\_\_

Additional therapies that may be necessary to assist you in reaching your goals are: \_\_\_\_\_

\_\_\_\_\_

Notice of Risk: The use of controlled substances may be associated with certain **risks such as, but not limited to:**

1. **Central Nervous System:** Sleepiness, decreased mental ability and confusion. Avoid alcohol while taking these medications and use care when driving and operating machinery. Your ability to make decisions may be impaired.
2. **Respiratory:** Depression (slowing) of respiration and the possibility of inducing bronchospasm (wheezing) causing difficulty in catching your breath in susceptible individuals. Worsening of sleep apnea including blocking of your windpipe that could be fatal. There is a risk that sleep apnea can be caused by use of these medications.
3. **Cardiac:** Heart rate may be dangerously irregular.
4. **Endocrine:** There may be a severe decrease in sex hormone production and possible other hormone production and/or regulation.
5. **Gastrointestinal:** Constipation is common and may be severe. Nausea and vomiting may occur as well.
6. **Dermatological:** Itching and rash.
7. **Depression:** Opioid medications may worsen depression and could increase the risk of suicide.
8. **Urinary:** Urinary retention (difficulty urinating).
9. **Pregnancy:** Newborn may be dependent on opioids and suffer withdrawal symptoms after birth.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician/Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_

(Please Print)



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## CAREMARK COMP VAS/FUNCTION ASSESSMENT

Date: \_\_\_\_\_

Worker Name: \_\_\_\_\_

Claim #: \_\_\_\_\_

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is “no pain” and 10 is “pain as bad as could be”? [That is, your usual pain at times you were in pain.]

No Pain Pain as bad as could be  
0      1      2      3      4      5      6      7      8      9      10

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is “no interference” and 10 is “unable to carry on any activities”?

No Interference Unable to carry on any activities  
0      1      2      3      4      5      6      7      8      9      10

Interpretation of the Two Item Graded Chronic Pain Scale – This two-item version of the Graded Chronic Pain Scale is intended for brief and simple assessment of pain severity in primary care settings. Based on prior research, the interpretation of scores on these items is as follows:

Pain Rating Item	Mild	Moderate	Severe
Average/Usual Pain Intensity	1-4	5-6	7-10
Pain-related Interference with Activities	1-3	4-6	7-10

Physician/Provider Name \_\_\_\_\_  
(Please Print)

Signature \_\_\_\_\_



503-413-1234  
877-270-5566  
www.legacyhealth.org/labservices

Physician Full Name: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**SECTION 1: DEMOGRAPHIC INFORMATION**

ICD-9 / DX CODE (REQUIRED) 1. _____ 2. _____ 3. _____ 4. _____		SEND BILL TO PATIENT/INSURANCE		DUPLICATE REPORT TO: (PROVIDER'S FULL NAME & ADDRESS)	
PATIENT'S LEGAL NAME (LAST, FIRST, MI)			PREVIOUS NAME		
PATIENT'S SOCIAL SECURITY NUMBER		SEX	DATE OF BIRTH		
MAILING ADDRESS (REQUIRED FOR INSURANCE & PATIENT BILLING)					
CITY/STATE		ZIP	PATIENT PHONE NO. (      )		
INSURANCE NAME <b>CAREMARK COMP</b>					
CLAIM #					
BILLING USE ONLY <b>CCLAO</b>					
			<b>SECTION 2: COLLECTION INFORMATION</b>		
PHOTO I.D. CHECKED <input type="checkbox"/>					
(OPTIONAL) TEMPERATURE OF SPECIMEN 90°-100° <input type="checkbox"/> YES <input type="checkbox"/> NO					
COLLECTION TIME:      AM      PM (CHECK ONE)					
COLLECTOR NAME: _____					
COLLECTOR'S SIGNATURE _____ / _____ DATE					

**SECTION 3: PATIENT CONSENT AND AUTHORIZATION**

I consent and certify that the above information is correct and the specimen collected is my own. In addition, I authorize any holder of medical, or other information about me, to release to the insurance company, Legacy Laboratory Services, and their agents, information to determine these benefits for related services. I understand that I am financially responsible for all services performed by Legacy Laboratory Services, whether or not they are paid by insurance.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 4: TEST REQUESTED**

MedManager™ Panel - Urine (PMC PAN)

LEGACY LABORATORY USE ONLY					MED BENCH ↓	
U						
URINE	Rec'd By	ROE	AUDIT	EDIT	QNS	LEAKED IN TRANSIT

**SECTION 5: PAIN MEDICATION INFORMATION**  
MARK ALL MEDS TAKEN WITHIN LAST 5 DAYS

**OPIOIDS:**

- BUPRENORPHINE (SUBUTEX)
- CODEINE (TYLENOL #3)
- DIHYDROCODEINE
- FENTANYL (DURAGESIC)
- HYDROCODONE (VICODIN)
- HYDROMORPHONE (DILAUDID)
- METHADONE (DOLOPHINE)
- MEPERIDINE (DEMEROL)
- MORPHINE (MS CONTIN)
- OXYCODONE (OXYCONTIN)
- OXYMORPHONE (OPANA)
- PROPOXYPHENE (DARVON)
- TRAMADOL (ULTRAM)

**BENZODIAZEPINES:**

- ALPRAZOLAM (XANAX)
- CLONAZEPAM (KLONOPIN)
- DIAZEPAM (VALIUM)
- LORAZEPAM (ATIVAN)
- TEMAZEPAM (TRANXENE)
- OTHER BENZODIAZEPINES \_\_\_\_\_

**OTHER PAIN RELATED MEDICATIONS:**

- BUTALBITAL (FIORICET)
- OTHER PAIN RELATED MEDICATIONS: \_\_\_\_\_

**COURIER USE ONLY**



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**CAREMARK COMP  
OPIOID PAIN EVALUATION REFERRAL FORM**

Date: \_\_\_\_\_

Worker Name: \_\_\_\_\_ Claim #: \_\_\_\_\_

Ordering Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Condition(s) being treated: \_\_\_\_\_

Drug(s) Requested					
Medication	Dose	Frequency	Medication	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Does the request represent an increase in the opioid dose?       Yes       No

Please send this form along with chart notes that include opioid prescribing history to one of the following physicians. The Pain Management Specialist’s office will contact your patient to schedule the evaluation.

<p><b>Bradford Lorber, MD</b> Northwest Occupational Medicine Center 9400 SW Beaverton-Hillsdale Hwy, #205 Beaverton, OR 97005 Phone: (503) 684-7246 Fax: (503) 624-0724</p>	<p><b>Thomas Schratzenholzer, MD</b> Legacy Good Samaritan Pain Management Clinic 1130 NW 22<sup>nd</sup> Ave., #345 Portland, OR 97210 Phone: (503) 413-7513 Fax: (503) 413-7503</p>
<p><b>Matthew McGehee, MD</b> Progressive Rehabilitation Associates 1815 SW Marlow Ave., #110 Portland, OR 97225 Phone: (503) 292-0765 Fax: (503) 292-5208</p>	<p><b>Gary Ward, MD</b> Rehabilitation Medicine Associates PC 1040 NW 22<sup>nd</sup> Avenue #320 Portland, OR 97210 Phone: (503) 413-6294 Fax: (503) 413-7780</p>
<p><b>David Russo, DO, MPH</b> Columbia Pain Management PC 1010 Tenth St. Hood River, OR 97031 Phone: (541) 386-9500 Fax: (541) 386-9540</p>	