



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 INITIATING LONG-ACTING OPIOID USE
(Including Long-Acting Opioids Beyond 1 Week Post-Surgery)**

Date: _____

Worker Name: _____ Claim #: _____

Ordering Physician Name: _____

Address: _____

Phone: _____ Fax: _____

Drug(s) Requested					
Medication	Dose	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)



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CAREMARK COMP OPIOID RISK ASSESSMENT

Date: _____

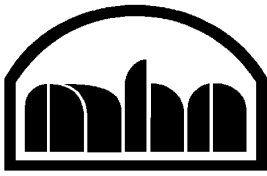
Worker Name: _____ Claim #: _____

		Mark Each Box That Applies	Item Score if Female	Item Score if Male
Family History of Substance Abuse	Alcohol	[]	1	3
	Illegal Drugs	[]	2	3
	Prescription Drugs	[]	4	4
Personal History of Substance Abuse	Alcohol	[]	3	3
	Illegal Drugs	[]	4	4
	Prescription Drugs	[]	5	5
Age (mark box if 16-45)		[]	1	1
History of Preadolescent Sexual Abuse		[]	3	0
Psychological Disease	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>Worker Signature _____</p> <p style="text-align: right;">Date _____</p>	<p>Physician/Provider Name _____ <small>(Please Print)</small></p> <p>Signature _____</p> <p style="text-align: right;">Date _____</p>
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Provider: Must renew Agreement every 6 months.



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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: _____

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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 _____

