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) ☐

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
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 ≥ 8

Physician/Provider Name: _____
(Please Print)

Signature: _____

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
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.

Worker Signature _____ **Date** _____

Physician/Provider Name _____ (Please Print)

Signature _____ **Date** _____

Provider: Must renew Agreement every 6 months.

Reference: Washington State Dept of Labor & Industries

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
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)

Reference: Oregon Anesthesiology Group

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
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 _____

Legacy Laboratory Services
503-413-1234
877-270-5566
360-487-1234
503-413-5048 fx
www.legacyhealth.org/labservices

MedManager

CAREMARK COMP OPIOID MGT 6770 (000) 000-9999

Last	Last	Last
First	First	First
Last	Last	Last
First	First	First

SPECIMEN COLLECTED
DATE:
TIME:
BY:
☐ PHOTO ID CHECKED
(Red Indicates Required)

Required Ordering Provider Information:
NAME(last,first) _____
ADDRESS: _____
PHONE #: _____

Dx CODE TO HIGHEST SPECIFICITY (REQUIRED)	SEND BILL TO (REQUIRED)	INSURANCE CO. NAME & ADDRESS (OR ATTACH COPY OF CARD)	PRE AUTHORIZATION #
1. 2. 3.	(___ CLINIC) (___ PATIENT/INS.)	CAREMARK COMP	
PATIENT'S LEGAL NAME (LAST, FIRST, MI) PREVIOUS NAME		INSURANCE ID NO.	GROUP NO.
PATIENT'S SOCIAL SECURITY NUMBER (REQUESTED) ___ ___ ___ - ___ ___ - ___ ___ ___ ___	SEX / DATE OF BIRTH	MEDICAID / OMAP I.D. NO.	MEDICARE NO. & LETTER ☐ ABN SIGNED (PLEASE ATTACH)
MAILING ADDRESS (REQUIRED FOR INSURANCE & PATIENT BILLING) APT #		COMMENTS: BILLING USE ONLY: CCLAO	
CITY/STATE ZIP PATIENT PHONE NO. ( )			

LEGACY LABORATORY USE ONLY	SS SST TUBE	L LAVENDER	U URINE	B BLUE	R RED	GY GRAY	GN GREEN	S SERUM	P PLASMA	ROYAL BLUE	C CULTURE	Y YELLOW	F FROZEN	LCX	MISC	REC'D BY	ROE	AUDIT	EDIT

COLLECTION INFORMATION: Photo ID Checked [ ]
(Optional) Temperature of Specimen 90-100 F [ ] YES [ ] NO Collection time: AM PM (Circle One)

Collector Name: _____

_____ / _____
Collector's Signature Date

PATIENT CONSENT AND AUTHORIZATION
I certify that the urine specimen provided for this testing is my own and that it was not adulterated or tampered with in any way. I authorize release of the results from this testing to all agencies/entities entitled to receive them. I also understand that I am personally financially responsible for all services provided by Legacy Laboratory Services whether or not they are paid by insurance.

Patient Signature: _____ Date: _____

TEST(S) REQUESTED
MedManager Panel - Urine (PMC PAN)
ADDITIONAL TESTS REQUESTED:
[ ] Ethyl Glucuronide (U M ETG)

PAIN MEDICATION INFORMATION
Mark all Meds taken within last 5 days

OPIOIDS:
[ ] BUPRENORPHINE (SUBUTEX)
[ ] CODEINE (TYLENOL #3)
[ ] 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)
[ ] CLORAZEPATE (TRANXENE)
[ ] DIAZEPAM (VALIUM)
[ ] LORAZEPAM (ATIVAN)
[ ] TEMAZEPAM (RESTORIL)
[ ] OTHER BENZODIAZEPINES _____

OTHER PAIN RELATED MEDICATIONS:
[ ] BUTALBITAL (FIORICET)
[ ] GABAPENTIN (NEURONTIN)
[ ] MEPROBAMATE/CARISOPRODOL (SOMA)
[ ] OTHER PAIN RELATED MEDICATIONS: _____

MISCELLANEOUS:
[ ] AMPHETAMINE (ADDERALL)
[ ] NO MEDICATIONS