Washington State Health Care Authority

COMMUNITY HEALTH PLAN of Washington™
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Opioid Attestation

Please provide the information below, attach supporting documentation, sign, date, and fax to Express Scripts at **1-877-251-5896** as soon as possible to expedite this request. Without this information, your request may be denied. Please call **800-753-2851** for assistance with submitting a prior authorization request. **This form is effective as of May 1, 2020.**

Date of request	CHPW Member ID	ProviderOne ID	Diagnosis	
Patient name		Patient date of birth	Patient telephone	Patient address
Pharmacy name		Pharmacy NPI	Pharmacy telephone	Pharmacy fax
Prescriber		Prescriber NPI	Prescriber telephone	Prescriber fax

Medication and strength	Directions for use	Qty/Days supply
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This form is required when patients begin chronic use of opioid, when daily opioid doses exceed 120 MME, or when both occur. Use of any opioid for more than 42 days within a 90 day period is considered chronic use. Use of opioids, either as a single prescription or multiple prescriptions, which result in doses above 120 morphine milligram equivalents (MME) per day requires a mandatory consultation with a pain management specialist or be prescribed by a pain management specialist as defined by section 3.a.iv.1-5. Chronic opioid use and doses above 120 MME may be authorized in 12 month intervals when the prescriber signs this attestation. **If a prescriber wants an attestation to be authorized for less than 12 months**, the prescriber must include a specific end date below. For patients receiving opioids for the treatment of pain relating to active cancer treatment, hospice, palliative or end-of-life care, the consultation is not required for authorization, but it is still encouraged.

Please review the Prescription Monitoring Program (PMP) to **verify all opioids your patient is currently receiving**. Use the SUPPORT Act HCA MME Conversion Factor document (https://www.hca.wa.gov/billers-providers-partners/programs-and-services/opioids) to **calculate the total prescribed MME**.

1. **Intended use and dose of opioid**
   - a. ☐ Acute non-cancer pain. Specify MME: _____
     - i. ☐ > 120 but ≤ 200 per day (Complete section 3 and 4); or
     - ii. ☐ > 200 MME per day (Complete section 3 and 4; supply medical records supporting the medical need)
   - b. ☐ Chronic non-cancer pain (> 42 days of opioid therapy is needed in a 90 day period). Specify MME: _____
     - i. ☐ ≤ 120 MME per day (Complete sections 2 and 4)
     - ii. ☐ > 120 but ≤ 200 per day (Complete section 2 thru 4); or
     - iii. ☐ > 200 MME per day (Complete section 2 thru 4; supply medical records supporting the medical need)
   - c. ☐ Active cancer pain, hospice, palliative, or end-of-life care. Specify MME: _____
     - i. ☐ ≤ 120 MME per day (Pharmacy may re-submit claim with EA Code: 85000000540); or
     - ii. ☐ > 120 but ≤ 200 per day (Complete section 3 and 4); or
     - iii. ☐ > 200 MME per day (Complete section 3 and 4; supply medical records supporting the medical need)

2. **Chronic Opioid Attestation**
   - a. Criteria for chronic use of opioids for the treatment of non-cancer pain:
     - i. My patient has an on-going clinical need for chronic opioid use at the prescribed dose (more than 42 days per 90 day calendar period) that is documented in the medical record; AND
     - ii. My patient is using appropriate non-opioid medications, and/or non-pharmacologic therapies; OR
     - iii. My patient has tried and failed non-opioid medications and non-pharmacologic therapies for the treatment of this pain condition; AND
     - iv. For long-acting opioids, my patient has tried a short-acting opioid for at least 42 days or there is clinical justification why short-acting opioids were inappropriate or ineffective; AND
     - v. I have recorded your patient's baseline objective pain and function scores and conduct periodic assessments in order to demonstrate clinically meaningful improvements in pain and function; AND
     - vi. I have screened my patient for mental health disorders, substance use disorder, naloxone use; AND
     - vii. I conduct periodic urine drug screens of my patient; AND
     - viii. I check the PDMP to determine if my patient is receiving other opioid therapy and concurrent therapy with benzodiazepines and other sedatives; AND
     - ix. I discussed with my patient the realistic goals of pain management therapy, including discontinuation of opioid therapy as an option during treatment; AND
     - x. I have confirmed that my patient understands and accepts these conditions and my patient has signed a pain contract or informed consent document.

b. The requested treatment is medically necessary, does not exceed the medical needs of the member, and is documented in my patient's medical record: ☐ Yes ☐ No

c. I attest that all of the above criteria are met, or there is documentation in my patient's medical record for why one or more are not applicable: ☐ Yes ☐ No

3. Opioid High Dose Attestation

a. Clinical reason for opioid doses MME > 120 per day, including doses > 200 MME per day :

i. ☐ My patient has active cancer pain, palliative care, end of life care or is in hospice requiring an opioid dosage that exceeds 120 MME per day; OR

ii. ☐ My patient has a medically necessary need requiring a temporary opioid dosage that exceeds 120 MME per day, **for no more than 42 days**; AND (check the box below that applies):

1. ☐ I am prescribing opioids for an acute medically necessary need, I have reviewed the Prescription Monitoring Program (PMP) and understand my patient is on chronic opioid therapy from another prescriber, and I have coordinated care with the other opioid prescriber; OR
2. ☐ I am the prescriber of the chronic opioid therapy; OR
3. I am prescribing opioids for my patient for one of the following reasons:
   a. ☐ Discharge from hospital
   b. ☐ Surgery
   c. ☐ Other trauma; OR

iii. ☐ My patient is following a tapering schedule with a starting dose > 120 MME per day; OR

iv. ☐ My patient has a medically necessary need to exceed 120 MME per day documented in the medical record; AND (check the box below that applies):

1. ☐ I am a pain management specialist as defined in WAC 246-919-945; OR
2. ☐ I have successfully completed a minimum of twelve category I continuing education hours on chronic pain management within the previous four years. At least two of these hours must have been dedicated to substance use disorders; OR
3. ☐ I am a pain management physician working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; OR
4. ☐ I have a minimum of three years of clinical experience in a chronic pain management setting, and at least thirty percent of their current practice is the direct provision of pain management care; OR
5. ☐ I have consulted with a pain management specialist regarding use of high dose opioids (> 120 MME per day) for this patient through one of the methods below and it is documented in the medical record:
   a. An office visit with patient, prescriber and pain management specialist; OR
   b. Telephone, electronic, or in-person consultation between the pain management specialist and the prescriber; OR
   c. An audio-visual evaluation conducted by the pain management specialist remotely where the patient is present with either the physician or a licensed health care practitioner designated by the physician or the pain management specialist.

b. The requested treatment is medically necessary, does not exceed the medical needs of the member, and is documented in my patient's medical record: ☐ Yes ☐ No

c. I attest that all of the above criteria are met, or there is documentation in my patient's medical record for why one or more are not applicable: ☐ Yes ☐ No

4. **For temporary opioid doses that exceed 120 MME per day, this attestation will expire in 42 days**; for all others this attestation will expire in 12 months unless you specify that you would like an earlier end date.

Please specify if you would like an earlier end date: _____

By signing below, I certify that the information on this form is true and understand that any misrepresentation or any concealment of any information requested may subject me to an audit. **Supporting documentation is required for requests exceeding 200 MME per day**.

Prescriber signature	Prescriber specialty	Date