ArrayRx PO Box 40168
Portland, OR 97240-0168

Uniform Medical Plan

Opioid Attestation

Please fax responses to: 1-800-207-8235
For more information call: 888-361-1611

This form is required when patients are using opioids chronically or when daily opioid doses reach 120 MME or greater. This form may authorize use for a maximum of 12-months. Please review the Prescription Monitoring Program (PMP) to verify all opioids and other controlled medications your patient is currently receiving. In this policy:

- **Chronic use** means use of any opioid or combination of opioids for more than 42 days within a 90-day period or use of any long-acting opioid
- **High dose use** means use of any opioid or combination of opioids at a high dose (≥120 MME per day).

This opioid attestation form does not need to be completed for members receiving opioids for the treatment of pain relating to active cancer treatment, hospice, palliative care, end-of-life care, or sickle cell disease.

Patient	Date of birth	UMP Member ID#

Pharmacy name	Pharmacy NPI (if known)	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number

Medication and strength	Directions for use (if known)

Criteria for chronic use of opioids or high-dose opioids for the treatment of pain not relating to active cancer treatment, hospice care, palliative care, end-of-life care, or sickle cell disease:

1. The need for chronic opioid use (more than 42 days per 90-day calendar period or use of long-acting opioids) and/or high dose opioids (≥ 120 MMEs per day) is medically necessary and is documented in the medical record; AND
2. The patient is currently using or has tried and failed appropriate non-opioid medications, and/or non-pharmacologic therapies; AND
3. The provider has recorded baseline and ongoing assessments of measurable, objective pain scores and function scores. These should be tracked serially in order to demonstrate clinically meaningful improvements in pain and function; AND
4. The patient has been screened for mental health disorders, substance use disorder, and naloxone use; AND
5. The provider has or will conduct periodic urine drug screens; AND
6. The provider has checked the PMP for any other opioid use and concurrent use of benzodiazepines and other sedatives; AND
7. If opioids are being prescribed by any other prescriber, the provider has coordinated care with the other prescriber; AND

INDICATE WHICH APPLIES:

☐ **For chronic opioid use:**

- The patient must be using or had trials of short-acting opioid therapy for at least 42 days; OR
- The reason for inadequate response to short-acting opioid therapy is documented in the medical record; OR
- Justification of beginning an opioid naïve patient on a long-acting opioid is documented in the medical record;

☐ **For high-dose opioids (≥ 120 MME per day):**

- The provider is a pain management specialist as defined in WAC 246-919-945; OR

- The provider successfully completed a minimum of twelve category 1 continuing education hours on chronic pain management within the previous four years and at least two of these hours were dedicated to substance use disorders; OR
- The provider is a pain management physician working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; OR
- The provider has a minimum of three years of clinical experience in a chronic pain management setting, and at least thirty percent of the providers current practice is the direct provision of pain management care; OR
- The provider has consulted with a pain management specialist regarding use of high dose opioids (≥ 120 MME per day) for this patient which is documented in the medical record; OR
- The patient is following a tapering schedule with a starting dose ≥ 120 MME per day; AND

8. The provider has discussed with the patient the realistic goals of pain management therapy and has discussed discontinuation as an option during treatment; AND
9. The provider confirms that the patient understands and accepts these conditions, and the patient has signed a pain contract or informed consent document.

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

The requested treatment is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical record ☐ Yes ☐ No

When should this treatment plan expire? Please specify date in MM/DD/YYYY format: _____

Note: The attestation form will expire on the date specified above or 12 months after the date of signature, whichever is soonest.

By signing below, I attest that the information on this form is true and understand that any misrepresentation or any concealment of any information requested may subject me to recoupment upon an audit.

Prescriber Signature	Effective Date of Attestation	Date of Signature