SoonerCare
Oklahoma Health Care Authority

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

Statement of Medical Necessity for Opioid Morphine Milligram Equivalent (MME) Limit Override

PRIOR AUTHORIZATION INFORMATION

Member Name:	Member ID Number:
Member Date of Birth:	Pharmacy Phone Number:
Pharmacy Name:	Pharmacy Fax Number:
Pharmacy NPI:	Drug Name & Strength:
NDC:	Requested Quantity & Days' Supply:
Dosing Regimen:	Fill Date:
Prescriber Name:	Prescriber NPI:
Prescriber Phone Number:	Prescriber Fax Number:

REASON FOR OVERRIDE

1. Specific diagnosis: _____
2. Detailed description of reason patient needs a quantity greater than 100 MME per day:

_____

_____

_____

3. Entire opioid regimen (medication name, strength, and dosing). Please list all opioid medications member is currently taking or planning to use: _____

_____

4. Has the member attempted an opioid taper? Yes_____ No_____
   a. If yes, please provide date of opioid taper, opioid MME level achieved, and reason for failure:

      _____

   b. If no, please provide patient-specific reasoning why a taper is not an option for the member:

      _____

5. Will the patient's pain be reassessed in the first month after the initial prescription or any dose increase AND every 3 months thereafter to ensure that clinically meaningful improvement in pain and function outweigh risks to patient safety? Yes_____ No_____
6. Has the prescriber reviewed the Oklahoma Prescription Monitoring Program (PMP) profile for the member in the last 30 days? Yes_____ No_____
7. Has the prescriber offered a prescription of naloxone to the member or member's household? Yes_____ No____
8. Does the prescriber and member have a signed pain management/opioid treatment agreement contract that is stored in the member's medical record? Yes_____ No____

Prescriber's signature: _____ Date: _____

Please do not send in chart notes. Failure to complete this form in full will result in processing delays. By signature, the prescriber or pharmacist confirms the above information is accurate.