Chronic Opioid Attestation

COMMUNITY HEALTH PLAN of Washington™
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Please provide the information below, please print your answer, attach supporting documentation, sign, date, and fax to Express Scripts at 877-328-9799.

Without this information, we may deny the request in three (3) business days.

For more information go to: https://www.hca.wa.gov/billers-providers/programs-and-services/opioids

Date of request	Reference # (if known)	CHPW ID	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength		Directions for use	

Use of any opioid for more than 42 days within a 90 day period is considered chronic use. Use of opioids for more than 42 days may be authorized in 6 month intervals when the prescriber signs the attestation below. Quantity limits do not apply for existing chronic users or those with a diagnosis or pharmacy claim for active cancer treatment, hospice, palliative care, or end-of-life care.

Criteria for chronic use of opioids for the treatment of non-cancer pain:

- The 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.
- The patient is using appropriate non-opioid medications, and/or non-pharmacologic therapies; OR
- The patient has tried and failed non-opioid medications and non-pharmacologic therapies for the treatment of this pain condition; AND
- For long-acting opioids**,** 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 opiate naïve patient on a long-acting opioid is documented in the medical record;
- 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
- The patient has been screened for mental health disorders, substance use disorder, naloxone use; AND
- The provider will conduct periodic urine drug screens; AND
- The provider has checked the PDMP for any other opioid use and concurrent use of benzodiazepines and other sedatives; AND
- The provider has discussed with the patient the realistic goals of pain management therapy and has discussed discontinuation as an option during treatment; AND
- The provider confirms that the patient understands and accepts these conditions and the patient has signed a pain contract or informed consent document.

1. 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

2. 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

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 recoupment upon an audit.

Prescriber signature	Prescriber specialty	Date