Select Health of South Carolina

Healthy Connections

PERFORMRx℠

Request Form for Short-Acting Opioid Medications

Fax to **PerformRx℠** at **1- 866-610-2775**, or to speak to a representative call **1-866-610-2773**.
Form must be completed for processing.

Member Information

Member name:_____ Date of birth:_____

Address:_____ Phone:_____

City:_____ State:_____ ZIP: _____

Member ID:_____ Preferred language:_____

Provider Information

Provider name:_____ NPI #:_____

Practice name:_____ Phone:_____

Address:_____ Fax:_____

City:_____ State:_____ ZIP:_____

Office manager:_____ Email:_____

Requested drug name, strength, and dosage form:_____

Directions:_____ Duration of therapy:_____

Diagnosis:_____ ICD-10 code:_____

Does the patient have cancer, sickle cell disease, or are they in hospice? ☐ Yes ☐ No

Is the prescriber a pain specialist, oncologist, hospice physician, hematologist, or surgeon? ☐ Yes ☐ No

If no, is the prescriber working in consultation with one of the above specialists? ☐ Yes ☐ No

If yes, please indicate the type of specialist:_____

Request Form for Short-Acting Opioid Medications

For initial requests

Prescriber attests to the following:

- For short-acting products, the diagnosis is acute pain or breakthrough? ☐ Yes ☐ No

- If the request is for a dose greater than 200 morphine milligram equivalents (MMEs) per day, provide documentation of medical necessity for the requested dose below or submit along with this form (i.e., titration of the dose to above 200 MMEs).

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- The prescriber attests to checking the prescription drug monitoring program called SCRIPTS.
  ☐ Yes ☐ No

- The prescriber attests to a titration of the dose requested: "If using for breakthrough pain, dose requested is 10 percent – 20 percent of total daily analgesic dose." ☐ Yes ☐ No

_____

- The prescriber attests to discussing with the patient the level of risk for opioid abuse/overdose with the dose/duration prescribed, and has the patient's signature on file acknowledging eduation.
  ☐ Yes ☐ No

- The prescriber attests to discussing concomitant psychological disease and risks associated with opioid overdose/abuse, and has the patient's signature on file acknowledging eduation.
  ☐ Yes ☐ No

- The prescriber attests to discussing history of substance use and the risks associated with opioid overdose/use, and and has the patient's signature on file acknowledging eduation.
  ☐ Yes ☐ No

- If the request is for a product not currently on the Select Health preferred drug list (PDL), then documentation must be submitted of prior therapy tried and failed and/or a medical reason for requesting this product:

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Prescriber signature:_____ Date:_____