High-Dose Opioid Regimen Checklist

PLEASE FAX BACK TO (831) 430-5851

Member name:	ID #:	DOB:
Opioid Requested (with strength):		Quantity (per days' supply):
ICD 10:		SIG:

PLEASE INCLUDE THE FOLLOWING WITH EACH REQUEST:

1. **Attach chart notes and/or relevant documents supporting that a pain assessment was performed.**
   a. Pain Score:_____.
   b. Tool used:_____
2. **Controlled Substance Utilization Review and Evaluation System (CURES) attestation. Check box if you agree.**

   ☐ I attest that I checked the member's CURES report and it does not indicate any concerns for opioid misuse and diversion.
3. **Document of plans for tapering/discontinuing opioids or identify rationale for not tapering/discontinuing:**

Signature: _____ **Date:** _____