Web Bill Processing Portal Office of Workers' Compensation Programs

Program: FECA Org. Name: ANGELA ATL & FLA TEST M.D. Provider ID: 001015621

LMN Form Submission

To view documents related to your submitted LMN requests, please click the 'LMN Documentation' hyperlink in the left navigation menu.

Instructions - CA 27 LMN Opioid Medications form
Instructions - CA 26 LMN Compounded Drugs form

OMB No. 1240-0055
Expires: 10/31/2019
Jan 2017

Please specify which type of LMN request you would like to Enter

- (•) Opioid (CA 27 LMN Opioid Medications)
- ( ) Opioid-Compounded (CA 27 LMN Opioid Medications)
- ( ) Non Opioid Compounded (CA 26 LMN Compounded Drugs)

Authorization Request form and Certification/Letter of Medical Necessity for Opioid Medications

This form is to be completed and signed by the patient's treating physician. Complete all sections of this form. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. The form is valid and effective for up to 60 days following the date of the treating physician's signature/certification.

Part A - Patient Information

1. *Last Name: *First Name: Middle Initial:
2. *Patient OWCP #: 3. Street Address:
4. *Date of Birth: mm dd yyyy 5. City: 6. State: Select
7. Zip: 8. Phone #:

Part B - Treating Physician Information

9. * Treating Physician Name: 10. *Treating Physician NPI #:
11. *Street Address: 12. *Provider ID#: 001015621
13. *DEA #: 14. * City: 15. *State: Select
16. *Zip: 17. * Phone #: 18. Secure Fax #:

Part C - Opioid Medication Information - PLEASE NOTE LIMIT OF TWO

19. *Medication Name(s): 20. *Primary Diagnosis:
21. *NDC(s): 22. *ICD-10 Code:
23. *Directions for use: 24. *Date of Last Physical Examination: mm dd yyyy
25. *Route of Administration (and Code) Select
26. *Anticipated Length of Therapy: Select
27. *Daily morphine milligram equivalent dose:

Add

Part D - Certification of Medical Necessity

28. *Have you accessed the requisite state Prescription Drug Monitoring Program, if available, regarding this patient's history of controlled substance prescriptions and will you do so every month thereafter?
( ) Yes ( ) No ( ) I do not have access to a [PDMP] in my state

29. *Will you enter this prescription information into your state's Prescription Drug Monitoring Program if you are required to update it as a dispensing provider? ( ) Yes ( ) No

30. *Have you completed a urine drug test for the above-named patient and will you do so periodically? ( ) Yes ( ) No

31. *Is the patient receiving a benzodiazepine from you or any other provider while receiving an opioid prescription?
( ) Yes ( ) No ( ) I do not have access to a [PDMP] in my state

32. *Have you discussed realistic benefits and known risks of opioid therapy with the patient, and have you advised the patient that serious risks include potentially fatal respiratory depression and development of a potentially serious lifelong opioid use disorder? ( ) Yes ( ) No

33. *Did you evaluate the use of non-opioid alternatives and conclude with reasonable medical certainty that the opioid's expected benefits for both pain and function outweigh the risk to the patient? SUPPLY NARRATIVE IN ITEM 40. ( ) Yes ( ) No

34. *Have you evaluated the patient for risk of opioid use disorder, potential need for medication-assisted treatment (MAT), and believe the medical benefit of prescribing the opioid outweighs the risk? SUPPLY NARRATIVE IN ITEM 40. ( ) Yes ( ) No

35. *Have you discussed with the patient the potential risk for opioid overdose or other adverse reaction and the steps the patient can take to reduce their risk, such as not combining their opioid with alcohol or other sedating substances? ( ) Yes ( ) No

36. *For patients who are at increased risk for overdose (as defined in the CDC guidelines) have you offered a prescription for overdose reversal (for example, naloxone) or counseled the patient to obtain naloxone from their pharmacy, where available without a prescription? ( ) Yes ( ) No

37. *Has use of the opioid medication(s) improved both pain and function for the patient? ( ) Yes ( ) No

38. *Is the opioid medication medically necessary for its intended use? ( ) Yes ( ) No

Ingredients

39. If the requested opioid medication is prescribed in a compounded drug, list opioid ingredients in box 21, complete the following for all other non-opioid active and inactive ingredients in the compounded drug; IF MORE THAN TEN ACTIVE/INACTIVE INGREDIENTS ARE BEING USED, LIST (INCLUDING NAME, NDC, QUANTITY, STRENGTH, AND MEDICAL NECESSITY FOR EACH) AND EXPLAIN THE NEED FOR MORE THAN TEN IN ITEM NUMBER 40. Only the most cost effective and medically necessary ingredients should be used. Herbal supplements, such as resveratrol, lavender oil, and alpha-lipoic acid, cannot be authorized on this form and will cause the form to be returned to the provider. Herbal supplements are authorized only on an exception basis on approval by the OWCP Chief Medical Officer or his/her designee.

*Drug Name *NDC(s)
*Quantity *Strength *Medically Necessary? ( ) Yes ( ) No

Add

40. * Provide a narrative explaining why the opioid medication is medically necessary. You may cite relevant medical literature to support your opinion on the necessity of the medication, particularly if the opioid is part of a compounded drug. You may be asked to provide clinical documentation and other relevant evidence to support use of this medication. The need for this medication is subject to review by claims staff and medical professionals. See instructions in item number 39 if the opioid is part of a compounded drug that has more than ten ingredients.

I certify that I am the treating physician for the above-named patient and that the medication requested is medically necessary and cost effective for the patient. I further certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge, and that documentation supporting this information is available for review if requested. I understand that any person who knowingly makes any false statement or misrepresentation to obtain prescription drugs from OWCP is subject to administrative penalties including provider exclusion; civil penalties including those under the False Claims Act and/or criminal prosecution. The submission of this form signifies my certification of the above and the on-file signature on my provider enrollment form is hereby incorporated by reference.

41. *Signature/CERTIFICATION of Patient's Treating Physician * ☐ Yes 42. Date mm 05 dd 26 yyyy 2017

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S3524, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Do not submit the completed claim form to this address. Persons are not required to respond to this information collection unless it displays a currently valid OMB number.

* denotes required fields

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