Pain Medication (OPIOID) Special Authorization Request Form
Workers' Compensation Board of Nova Scotia

WCB Claim # ☐☐☐☐☐☐☐☐
Mandatory

Please complete **all** sections clearly and with detail to allow your request to be processed without delay.
Use additional pages if necessary. This form must be completed by the prescriber **and submitted to Medavie Blue Cross [Fax (902) 496-5819]**.

Worker Information			
Last Name	First Name	Initial	DOB DD/MM/YYYY
Street	City	Postal Code	HCN

Injury Information		
If the injury is a sprain or strain, the use of an opioid beyond the acute phase is rarely indicated.		
Date of injury	Diagnosis	Comorbid conditions

Treatment Plan			
Requested product name and strength	Directions	Start date	Expected duration
Treatment goals and progress			
Rationale for need/ongoing use (other than pain control)?			

Medications tried for this condition **(Mandatory)**	Dosage	Duration	Outcome	Ongoing (Y/N)
What non-pharmaceutical therapies have been tried?				

IF THIS IS A FIRST START OF OPIOIDS FOR PATIENT – SKIP TO TOP OF PAGE 2

Please fill in the section below by describing your patient's response to opioids.

	Function	Pain
Please indicate the weekly average numerical level of function/pain since starting opioids.	0= return to pre-injury functional level 10 = severe impact on function at home and work ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10	0 = no pain at all 10 = persistent severe pain ○0 ○1 ○2 ○3 ○4 ○5 ○6 ○7 ○8 ○9 ○10
Has there been an overall improvement in function/pain since starting opioids?	○ Yes, comment below ○ No, comment below (e.g. regimen will be adjusted as follows, opioids will be discontinued with the following tapering schedule, other) Comments:	○ Yes, comment below ○ No, comment below (e.g. regimen will be adjusted as follows, opioids will be discontinued with the following tapering schedule, other) Comments:

If function is not improving, explain rationale for using opioid analgesics (other than pain control):

Please comment on the treatment plan to increase your patient's function:

Has your patient experienced any adverse effects and/or outcomes as a result of opioid therapy now or in the past? ○ Yes ○ No

If yes, please describe what these were and what is being done to manage/mitigate these risks.
Comments:

Is there a potential pre-existing and/or chronic psychosocial component to your patient's pain? ○ Yes ○ No

How is this being treated and managed? Please elaborate below.
Comments:

Please also submit the following:
WCB Substance Abuse Assessment Form
NOTE: A completed copy of the above form for this patient must be on file at Medavie Blue Cross before this request form will be processed.

Please indicate if the above listed form has been submitted previously: ○ Yes ○ No

If previously completed and there is any updated information you may have to share regarding substance abuse risk please provide it below.

Have you completed an opioid treatment agreement with your patient? ☐ Yes
NOTE: An opioid treatment agreement must be completed and acknowledged here before this request will be processed.

Date (DD/MM/YYYY) of next follow up visit :

Prescriber's name, address and fax/phone number	
Phone number _____ Fax number: _____ License #_____ **Mandatory**	_____ _____ Prescriber's signature Date DD/MM/YYYY

Physicians: use MSI fee code **WCB24**. Other prescribers: invoice WCB directly.

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Please return completed form to Medavie Blue Cross or by fax to (902) 496-5819
PO Box 2200
Halifax, NS B3J 3C6