Medicaid Opioid Lock-In Request Form

CareOregon

Revised 2025 • Please fax form to 503-416-8109

Patient Information

Last Name: _____ First Name: _____

DOB: _____ Member ID: _____

Instructions:

In the event multiple prescribers will be listed as the opioid prescribers for the member, one prescriber will be designated as the primary and the others can be listed in section B. All prescribers permitted to prescribe opioids as part of this patient's lock-in plan are required to sign in section B.

Only fill out the table in section C if you wish to restrict access to certain opioids instead of all opioids. Otherwise, leave the table blank.

Prescriber/Medication Information

A. Medical necessity and treatment appropriateness:

☐ Opioid restrictions are medically necessary.

B. The following prescribers are to be this patient's provider(s) of opioid prescriptions until the end of the lock-in (as specified in section C):

Primary prescriber:

Name: _____

Signature: _____ Date: _____

Second prescriber:

Name: _____

Signature: _____ Date: _____

Third prescriber:

Name: _____

Signature: _____ Date: _____

Add additional prescribers below as necessary (including signatures).

Fourth prescriber:

Name: _____

Signature: _____ Date: _____

Fifth prescriber:

Name: _____

Signature: _____ Date: _____

Sixth prescriber:

Name: _____

Signature: _____ Date: _____

C. Please indicate if the lock-in will apply to ALL opioids or to a specific opioid:

- ○ Restrict Access to All Opioids
- ○ Restrict Access to Certain Opioids Only (specify below)

Drug name (include strength & formulation)	Maximum daily dose

Lock-in information

Lock-in start date and duration:

Start date: _____ (leave blank for default of two weeks)

End date: _____ (leave blank for default of one year)

Attestation of patient consent to lock-in:

☐ I attest that I have discussed with the member the plan to restrict access to opioids to the above prescribers only. The member has agreed to the lock-in program for the start date and duration stated above.

Primary prescriber name: _____

Primary prescriber signature: _____

Date: _____ Number to call for questions: _____