DiversifyRx Demo Pharmacy
123 Main Street
Dallas, TX 75067

Dear Prescriber: _____ **Date:** _____

I am writing you regarding our patient, _____ DOB: _____

who has been prescribed the following: _____ (opioid).

As you may be aware, the Food and Drug Administration (FDA) and Centers for Disease Control and Prevention (CDC) advise:

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

Our patient is currently taking _____ MME/day of _____ (opioid).

PLEASE CONSIDER USE OF THE FOLLOWING INTERVENTIONS:

If expecting the patient to continue chronic use of _____ (opioid)

please consider tapering the dose of _____ (opioid)

- For patients who have been on long-term opioid treatment (LOT) for more than one year, we aim to taper by 10 percent of the starting dose every month.
- We aim to decrease by 10 percent of the starting dose by each week for patients who have been on LOT for less than one year.
- We typically prescribe approximately 50 percent fewer pills than the existing prescription, with the plan for the patient to self-taper by taking fewer pills for each dose over time. For patients who take opioids less frequently than daily, we do not formally prescribe a tapering schedule. In these patients, we discuss the target discontinuation date with the patient.

  Note: Taper guidance referenced from the literature review "**Opioid tapering for patients with chronic pain"** found at https://www.uptodate.com/contents/opioid-tapering-for-patients-with-chronic-pain#!

☐ If you **AGREE** with this recommendation, please fill out your tapering treatment plan on page 2 and forward it along with any needed new prescriptions to DiversifyRx Demo Pharmacy at your earliest convenience.

☐ If you **DISAGREE** with the above recommendations, please use page 2 to forward the current treatment plan with appropriate diagnosis codes and medical history justifying the continuation of current opioid therapy.

Please note if a tapering treatment plan or current justified treatment plan are not supplied to us by _____ we will no longer be able to dispense MAT medications for this patient.

The treatment plan request for our patient is being made to complete the continuum of care we provide and as documentation for the medication and quantity you prescribed and will be kept in a confidential file in our pharmacy.

If you have any questions or concerns regarding this recommendation, please do not hesitate to contact the pharmacy.

Thank you,

_____
Joe Pharmacist

Phone: 800-222-1212 Fax: 800-222-1212

TREATMENT PLAN REQUEST

To: DiversifyRx Demo Pharmacy

Patient Name: _____ **DOB:** _____

Medication: _____ **Quantity:** _____

Directions: _____

_____

Treatment Plan (if more space is needed, please attach additional pages): _____

_____

_____

_____

_____

_____

_____

_____

_____

I took these steps voluntarily due to the seriousness of, and rapid increase in the abuse of controlled substances. The safety of our patients and the public requires that all healthcare professionals increase vigilance to stem the abuse of these drugs and prevent death and injury.

Professionally yours,

_____ _____

Medical Practitioner Signature Date

_____

Medical Practitioner (Printed)

Practice Name: _____

Address: _____

City, State Zip: _____