

**Employer/Carrier Request to Health Care Provider for Additional Information  
Regarding Recommendation for Opioid Tapering or Discontinuation**

**TO BE COMPLETED BY THE CARRIER/EMPLOYER**

Patient Name: _____	Today's Date: _____
Patient ID #: _____	Date of Injury: _____
Employer: _____	Carrier: _____
Treating Provider: _____	IC File #: _____
TO RECOMMENDING HEALTH CARE PROVIDER: You recently recommended the following treatment(s) for the above-named employee: _____	
Your prompt completion and return of this form to the following person is appreciated: Name: _____ Telephone number: _____ Fax number: _____ Email address: _____	

**TO BE COMPLETED BY THE HEALTH CARE PROVIDER**

**Please provide the following additional information regarding the recommended treatment:**

1. What are the clinical goals of the recommended treatment(s)? \_\_\_\_\_  
\_\_\_\_\_
2. What measurable objective(s) is/are the treatment(s) expected to accomplish? \_\_\_\_\_  
\_\_\_\_\_
3. What is the estimated length of treatment(s)?  
Number of weeks: \_\_\_\_\_  
Number of visits per week, if applicable: \_\_\_\_\_  
Intervals at which progress will be measured: \_\_\_\_\_
4. Will medication assisted treatment be used in the tapering / weaning process?  Yes  No  
If yes, name and dosage of the medication(s) to be used:  
NAME OF MEDICATION: \_\_\_\_\_ DOSAGE: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Estimated length of medication assisted treatment, if known: \_\_\_\_\_
5. What is the projected outcome upon completion of the recommended treatment(s)? \_\_\_\_\_  
\_\_\_\_\_
6. Please provide any other relevant information supporting the treatment recommendation: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Provider Signature** \_\_\_\_\_

**Printed Name** \_\_\_\_\_ **Date** \_\_\_\_\_