Exceptional Access Program (EAP) Request Form: Oxycodone HCl Controlled Release Tablets (OxyNEO®)

Section1- Prescriber Information			Section 2- Patient Information		
First Name	Initial	Last name	First Name	Initial	Last name
Mailing Address Street no. / Street Name			Health Number		
City		Postal Code			
Fax Number	Telephone Number		Date of Birth (yyyy/mm/dd)		

☐ New Request ☐ Renewal Existing EAP Request Number (if applicable): _____

Section 3 - Drug Requested

Oxycodone hydrochloride CR (OxyNEO) tablets (Please indicate strength(s) requested):

☐ 10 mg ☐ 15 mg ☐ 20 mg ☐ 30 mg ☐ 40 mg **Note that EAP does not cover 60 mg or 80 mg tablets.**

Dose and Frequency of Administration	Duration of treatment

Section 4 – Diagnosis and Reason(s) for Use (Complete this section if applying for OxyNEO through EAP the first time)

EAP OxyNEO Criteria:
For the treatment of chronic pain in patients who have experienced intolerance or have failed an adequate trial (for example three months) of at least one other listed long-acting opioid product.

Note: Prescribers may consider referring to the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain as published by the National Opioid Use Guideline Group (NOUGG) for additional information regarding opioid use (available at http://nationalpaincentre.mcmaster.ca/opioid/). Please refer to the attached checklist.

For the EAP to determine if your patient's circumstances meet EAP's reimbursement criteria, please complete the questions below. To avoid delays in your request you MUST answer all questions that apply.

1. What is the patient's diagnosis for which pain management is being requested?

   _____

2. Is this a chronic condition? ☐ Yes ☐ No Note that OxyNEO is reimbursed only for chronic pain conditions.

Section 5 – Medication: Current and/or Previous

Please indicate or provide names of long-acting opioid products used, including why the product is not appropriate. Include the patient's prior use of OxyContin if applicable.

Name of drug (indicate if currently or previously taken)		Dose/frequency	Approximate date/year when used	Reason(s) why formulary alternatives are not appropriate
Hydromorph Contin	☐ Current ☐ Previous			☐ Intolerance ☐ Failed therapy
Sustained release morphine (e.g., Kadian, M-ESLON, MS Contin, generics)	☐ Current ☐ Previous			☐ Intolerance ☐ Failed therapy
Transdermal fentanyl (e.g., DURAGESIC MAT, generics)	☐ Current ☐ Previous			☐ Intolerance ☐ Failed therapy
Codeine Contin	☐ Current ☐ Previous			☐ Intolerance ☐ Failed therapy
Methadone	☐ Current ☐ Previous			☐ Intolerance ☐ Failed therapy

Other drug therapies:

Note: Prescribers are encouraged to review and consider the check list on the next page when prescribing OxyNEO or other opioids for chronic pain management.

Prescriber Signature (mandatory)	CPSO number:	Date (yyyy/mm/dd)

Fax the completed form and/or any additional/relevant information to (416) 327-7526 or toll-free to 1-866-811-9908; or send your request to the Ontario Public Drug Programs, Exceptional Access Program Branch, 3rd Floor, 5700 Yonge Street, Toronto, ON, M2M 4K5.