QUALITY INTERDISCIPLINARY REVIEW COMMITTEE (QIRC) CASE SUBMISSION FORM

**PATIENT ACCOUNT#: PCP: Are you the PCP? Yes No**

**PAIN DIAGNOSIS/ICD-10: Date Submitted for review:**

**SUBMITTING PROVIDER’S SPECIFIC CONCERNS:**

***Check at least 1 option below to identify the qualifying reason for evaluating this patient/case***

* **90 MME/day**
* **Use Disorder (AUD, OUD, SUD, Benzo Dependence, Kratom) with concurrent psychiatric disorder or Behavioral health concern)**
* **Patients wanting to transition from full agonist opioids to Partial Agonists, then once stabilized transitioned back to primary care provider**
* **Tapering recommendations for opioids or benzodiazepines or other controlled substances**
* **Safe prescribing**
	+ **Suspicious behavior/diversion/early refill requests/inconsistent utox**
	+ **Combinations: benzo + opioids, opioids + sedatives, stimulants + opioids and/or benzos**
	+ **ETOH use and/or illicit drug use and on controlled medications**
	+ **No identifiable source of pain on workup, no previous or adequate workup, no safer/conservative measures taken to treat patient prior to treating patient with controlled medications**
	+ **Concerning patient cases (while covering for a provider) on high risk controlled medications and/or concerning prescribing of controlled medications by PCP.**

***Please complete the medication chart***

|  |  |  |
| --- | --- | --- |
| **CURRENT MEDICATION/ DOSAGE** | **FREQUENCY** | **MME/Day** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  | TOTAL MME/DAY: |  |

*\_\_\_\_\_\_\_\_\_\_Committee Evaluation completed on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Are the following up to date? DOJ CSA SBIRT*

*Inconsistent UTOXes in past? Yes No*

 *Comments on UTOX history:*

*Appropriate work-up for etiology of pain? Yes No*

 *Comments on pain work-up:*

*Quality Interdisciplinary Review Committee Recommendations:*