**Please note that only you - as the person taking the medication - can best justify the use of it. If the WC denies the medication, you will have the following considerations:**

1. TPM will reduce and wean you off the medication and will not prescribe the medication in the future. (mostly applies to pain medications, sleeping medications, muscle relaxants)
2. You may pay for the medication on your own, if TPM is willing to continue to prescribe.
3. You may consider using other insurance for the same (if appropriate/legal)
4. You may consider filing an Independent Medical Review (IMR). In our experience, almost all appeals against the denial of pain medications have been upheld in favor of the WC Company. Such denials are good for 12 months in general.

**If the insurance company/IMR has denied the medication, please DO NOT expect WC to pay for the same.**

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**Most WC companies expect "30%" reduction in the pain with the use of pain medication.**

## Examples of activities/functional improvement:

1. Personal:
   a. Sleep uninterrupted/longer duration
   b. Able to bathe /shower, use restroom independently
   c. Able to sit at the dining table with family
   d. Able to dress/ put makeup/wear socks & shoes etc.
   e. Able to drive – without interruptions
   f. Able to exercise, go to gym
2. Family/Home:
   a. Watch TV with family
   b. Pickup mail from the mailbox
   c. Clean, vacuum
   d. Do laundry, wash dishes, mop
   e. Garden, plant
   f. Housekeeping
   g. Work in the garage/yard – fix things, paint
   h. Mow lawn, remove weeds
   i. Visit friends & relatives
   j. Play with children/ grandchildren, lift them, carry them
   k. Take care of elderly parents/spouse/relatives
   l. Go shopping for groceries etc.
   m. Go to kids games
3. Recreational:
   a. Go on vacation/able to take flights
   b. Drive long distance
   c. Fish, hunt
   d. Camping, hiking, back packing
   e. Visit relatives out of town
4. Work related:
   a. Employed fulltime or PT or modified duty
   b. Volunteer at church/school
   c. Help neighbors, friends
   d. Sit at a desk, use computer

**Patient LAST NAME**: ____________________ **FIRST NAME**: _______________ **Date of Birth:** _________________

**WC Insurance Company**: ____________________________ **Claim #**: _______________________________________

**Medication # 1:** ________________ **Strength:** ______________ **How Often:** __________________________________

**How does this medication help you? (Also, if this is a pain medication please include detailed functional improvement / activity improvement and % improvement of pain):**

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

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**What would happen without this medication?** ___________________________________________________________

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_____________________________________________________________________________________________________

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_____________________________________________________________________________________________________

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**Medication # 2:** ________________ **Strength:** ______________ **How Often:** __________________________________

**How does this medication help you? (Also, if this is a pain medication please include detailed functional improvement / activity improvement and % improvement of pain):**

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**What would happen without this medication?** ___________________________________________________________

_____________________________________________________________________________________________________

_____________________________________________________________________________________________________

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_____________________________ _____________________________

**Patient Signature** **Date of Signature**