

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax attention to:			

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

Yes No Does the prescriber attest to ALL of the following?

- *The information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.*
- *Treatment goals are defined, including estimated duration of treatment.*
- *Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention*
- *Patient has been screened for substance abuse/opioid dependence*
- *If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression.*
- *Pain is moderate to severe and expected to persist for an extended period of time*
- *Pain is chronic*
- *Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time)*
- *Pain management is required around the clock with a long-acting opioid*

Prescriber's Signature: _____ Date: _____

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the requested medication being used for any of the following? <i>(If yes, check which applies)</i></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"><input type="checkbox"/> Cancer related pain</td> <td style="width:50%; border: none;"><input type="checkbox"/> Hospice care related pain</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> End-of-life care related pain</td> <td style="border: none;"><input type="checkbox"/> Non-cancer, non-hospice, or non-end of life related pain</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Palliative care</td> <td style="border: none;"><input type="checkbox"/> Skilled nursing facility care</td> </tr> <tr> <td colspan="2" style="border: none;"><input type="checkbox"/> Traumatic injury, including burns and excluding post-surgical procedures</td> </tr> </table>	<input type="checkbox"/> Cancer related pain	<input type="checkbox"/> Hospice care related pain	<input type="checkbox"/> End-of-life care related pain	<input type="checkbox"/> Non-cancer, non-hospice, or non-end of life related pain	<input type="checkbox"/> Palliative care	<input type="checkbox"/> Skilled nursing facility care	<input type="checkbox"/> Traumatic injury, including burns and excluding post-surgical procedures	
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<input type="checkbox"/> Traumatic injury, including burns and excluding post-surgical procedures									

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of failure, contraindication, or intolerance to Butrans or buprenorphine patch? <i>(If yes, complete Section D above)</i></p>
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CANCER/HOSPICE CARE/END-OF-LIFE CARE

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient being treated for cancer related pain?</p> <p><i>If yes, list diagnosis:</i></p> <p><i>Date of Diagnosis:</i></p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the prescriber attest to the following: the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information?</p>

NON-CANCER PAIN/NON-HOSPICE CARE/NON-END-OF-LIFE CARE PAIN

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the request for neuropathic pain (examples of neuropathic pain include neuralgias, neuropathies, fibromyalgia)?</p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Has the patient exhibited an inadequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose, unless it is contraindicated? <i>(If yes, complete Section D above)</i></p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Has the patient exhibited an inadequate response to 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose, unless it is contraindicated?</p> <p><i>(If yes, complete Section D above)</i></p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of failure, contraindication, or intolerance to a trial of tramadol IR?</p> <p><i>(If yes, complete Section D above)</i></p>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the request for postoperative pain and the patient is already receiving chronic opioid therapy prior to surgery or the postoperative pain is expected to be moderate to severe and persist for an extended period of time?</p> <p><i>List date and type of surgery:</i></p>

Member First name:		Member Last name:		Member DOB:	
CONTINUATION OF THERAPY & REQUESTS TO EXCEED THE 90 MME CUMULATIVE THRESHOLD					
<input type="checkbox"/> Yes <input type="checkbox"/> No		Has the patient demonstrated meaningful improvement in pain and function? <i>If yes, document improvement in function or pain score improvement:</i>			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Has rationale been identified for not tapering and discontinuing opioid? <i>List rationale:</i>			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Has the patient tried and failed non-opioid pain medication? <i>(If yes, complete Section D above)</i>			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Have opioid medication doses of less than 90 MME been tried and did not adequately control pain? <i>(If yes, complete Section D above)</i>			
QUANTITY LIMIT EXCEPTIONS					
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is there a reason or special circumstance that the patient requires a greater quantity of medication? <i>If yes, list reasoning:</i>			

Provider Signature: _____ **Date:** _____

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