ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Belbuca / Butrans - Colorado
Prior Authorization Request Form

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: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ 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? □ Yes □ 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 at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

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	
□ Yes □ No	**Is the requested medication being used for one of the following?** *(If yes, check which applies)* □ Cancer related pain □ Hospice care related pain □ End-of-life care related pain □ Non-cancer, non-hospice, or non-end of life related pain
□ Yes □ No	**For Belbuca or BRAND Butrans requests, is there a reason or special circumstance the patient cannot use generic buprenorphine patches?** *If yes, list reasoning:*
CANCER/HOSPICE CARE/END-OF-LIFE CARE	
□ Yes □ No	**Does the prescriber attest that 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?**
NON-CANCER PAIN/NON-HOSPICE CARE/NON-END-OF-LIFE CARE PAIN	
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to a trial of tramadol IR (immediate release)?** *(If yes, complete Section D above)*
□ Yes □ No	**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?**
□ Yes □ No	**Is the patient being treated for one of the following?** *(if yes, check which applies)* □ Pain that is non-neuropathic □ Neuropathic pain (e.g., neuralgias, neuropathies, fibromyalgia)
□ Yes □ No	**Has the patient exhibited an inadequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose, unless it is contraindicated?** *(If yes, complete Section D above)*
□ Yes □ No	**Has the patient exhibited an inadequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose, unless it is contraindicated?** *(If yes, complete Section D above)*
CONTINUATION OF THERAPY	
□ Yes □ No	**Has the patient demonstrated meaningful improvement in pain and function?** *If yes, document improvement in function or pain score improvement:*
□ Yes □ No	**Has rationale been identified for not tapering and discontinuing the opioid?** *If yes, document rationale:*

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REQUESTS TO EXCEED THE 90 MME CUMULATIVE THRESHOLD	
□ Yes □ No	**Has the patient tried and failed non-opioid pain medications?** *(If yes, complete Section D above)*
□ Yes □ No	**Have opioid medication doses of less than 90 Morphine Milligram Equivalents (MME) been tried and did not adequately control pain (see table below)?** *If yes, document drug regimen or MME and dates of therapy:*

EXCEED QUANTITY LIMITS

Please note the plan's quantity limits:

Brand	Active Ingredient	Max Dose*	90 MME Equivalent (mg/day) (non treatment naïve)
Belbuca	Buprenorphine (buccal film)	1800 mcg (900 mcg every 12 hours)	3000 mcg
Butrans	Buprenorphine (patch)	20 mcg/hour patch every 7 days	50 mcg/hour

□ Yes □ No	**Can the requested dose be achieved by moving to a higher strength of the product?**
□ Yes □ No	**Is the requested dose within FDA maximum dose per day, where an FDA maximum dose per day exists (see table)?**
CONCURRENT USE WITH BENZODIAZEPINE	
□ Yes □ No	**Is the patient currently established on concomitant therapy (i.e., not new to combination therapy) and continuation of therapy is medically appropriate?**
□ Yes □ No	**Does the provider attests that having conducted a risk/benefit analysis, concomitant opioid and benzodiazepine use by the patient is considered both beneficial and prudent?**
□ Yes □ No	**Does the provider attests to checking the prescription drug monitoring program (PDMP) periodically during treatment?**
□ Yes □ No	**Does the patient have health conditions that pose high risk with this combination therapy (e.g., sleep apnea, renal or hepatic insufficiency, etc.)?**
□ Yes □ No	**Is the patient taking a skeletal muscle relaxant (e.g., carisoprodol) concurrently?**
□ Yes □ No	**Has the patient been screened for substance use disorders?**

Provider Signature: _____ **Date:** _____