UnitedHealthcare Community Plan

Belbuca/Butrans – Rhode Island
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 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	**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	**Is the patient being treated for cancer related pain?** *If yes, list diagnosis:* *Date of Diagnosis:*
□ Yes □ No	**Has the prescriber provided a reason or special circumstance that the patient cannot use generic buprenorphine patches?** *If yes, list reason:*
CANCER/HOSPICE CARE/END-OF-LIFE CARE	
□ Yes □ No	**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?**
NON-CANCER PAIN/NON-HOSPICE CARE/NON-END-OF-LIFE CARE PAIN	
□ Yes □ No	**Is the patient being treated for one of the following?** *(if yes, check which applies)* □ Pain that is non-neuropathic □ Neuropathic pain or 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 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose, unless it is contraindicated?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to a trial of tramadol IR?** *(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?** *List date and type of surgery:*

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CONTINUATION OF THERAPY & REQUESTS TO EXCEED THE 90 MED CUMULATIVE THRESHOLD	
□ 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 opioid?** *List rationale:*
□ Yes □ No	**Has the patient tried and failed non-opioid pain medication?** *(If yes, complete Section D above)*
□ Yes □ No	**Have opioid medication doses of less than 90 MED been tried and did not adequately control pain?** *(If yes, complete Section D above)*
EXCEED QUANTITY LIMITS	

Please note the plan's quantity limits:

Brand	Active Ingredient	Max Dose*
Belbuca	Buprenorphine (buccal film)	1800 mcg (900 mcg every 12 hours)
Butrans	Buprenorphine (patch)	20 mcg/hour patch every 7 days

□ Yes □ No	**Is the requested dose within FDA maximum dose per day, where an FDA maximum dose per day exists (see table)?**
□ Yes □ No	**Can the requested dose be achieved by moving to a higher strength of the product?**
□ Yes □ No	**Is there a reason or special circumstance that the patient requires a greater quantity of medication?** *If yes, list reasoning:*

Provider Signature: _____ Date: _____