Cough and Cold (Opiate Combination) – Rhode Island

Prior Authorization Request Form

UnitedHealthcare Community Plan

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:
NPI #:	Phone:	Fax:	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

ALL REQUESTS:

- **Does the provider attest they are aware of the patient's current opioid therapy and MED dose and feels the treatment with the requested product is medically necessary? □ Yes □ No**

- **Has the patient had a history of failure, contraindication or intolerance to a trial of at least three preferred cough and cold products? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Requests for LESS THAN THE FDA APPROVED MINIMUM AGE:

- **Does the prescriber attest they are aware of FDA labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary? □ Yes □ No**
  If yes, list rationale for use: ______________________________
  ____

- **Does the patient have a comorbid condition that may impact respiratory depression? □ Yes □ No**
  (e.g., asthma or other chronic lung disease, sleep apnea, body mass index > 30)
  If yes, list comorbid condition: ______________________________
  ____

- **Has the patient tried and failed at least one non-opioid containing cough and cold remedy? □ Yes □ No**
  If yes, List non-opioid containing cough and cold remedy / reason for d/c: ______________________________
  ____

Requests to EXCEED QUANTITY LIMIT:

- **Does the prescriber attest that a larger quantity is medically necessary? □ Yes □ No**

- **Is there a reason why a greater quantity of medication is required to treat the patient's condition? □ Yes □ No**
  If yes, list reason: ______________________________

- **Is the requested dose within the FDA maximum dose per day, where an FDA maximum dose per day exists?**
  □ Yes □ No

Provider Signature: ______________________________ **Date:** ____________________

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