

## Cough and Cold (Opiate Combination) – Texas 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: <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 at [www.uhcprovider.com](http://www.uhcprovider.com) for a list of preferred alternatives

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

#### EXCEEDING CUMULATIVE MORPHINE MILLIGRAM EQUIVALENT (MME) OF 90 MG

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Does the patient meet any of the following conditions or care instances?</b> <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cancer diagnosis</li> <li><input type="checkbox"/> End of life care, including hospice care</li> <li><input type="checkbox"/> Palliative care</li> <li><input type="checkbox"/> Resident of a long-term care facility or another facility for which residents receive opioid substitution therapy for treatment of opioid use disorder (OUD)</li> <li><input type="checkbox"/> Sickle cell anemia</li> <li><input type="checkbox"/> The prescriber attests they are aware of patient’s current opioid therapy and MME dose and feels the treatment with the requested product is medically necessary</li> </ul>
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#### EXCEEDING THE QUANTITY LIMIT

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Does the prescriber attest that a larger quantity is medically necessary?</b></p>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<p><b>Does the requested dose exceed the FDA approved maximum dose per day, where an FDA maximum dose per day exists?</b></p> <p><i>If yes, list reason:</i></p>

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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