UnitedHealthcare Community Plan

Opioid Products - Arizona
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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Clinical and Drug Specific Information

□ Yes □ No	**Does the prescriber attest to ALL of the following?** *(If yes, signature required)*

- **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)**
- **If the request is for a long-acting opioid, pain management is required around the clock with a long-acting opioid**

Prescriber's Signature: _____ ***Date:*** _____

Opioid overdose reversal medications are a covered benefit without prior authorization. CDC guidelines recommend offering naloxone to patients at increased risk of overdose, defined as: history of overdose or substance use disorder, doses > 50 MED/day, or concurrent use with benzodiazepines. Please refer to Preferred Drug Plan for preferred products.

ALL REQUESTS

□ Yes □ No	**Does the patient have any of the following?** *(If yes, check which applies)* □ Active oncology diagnosis □ End-of-life care (other than hospice) □ Hospice care □ Palliative care □ Children on opioid wean at time of hospital discharge □ Post-surgical procedures □ Traumatic injury, excluding post-surgical procedures □ Skilled nursing facility care □ Prescriber attests that the patient is not opioid-naïve (check to attest and list start date below) *List start date:*
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to a trial of any preferred short acting opioids?** *(If yes, please complete Section D above)*
□ Yes □ No	**Does the patient have a history of failure, contraindication or intolerance to a trial of any of the following:** *(If yes, check all that apply and complete Section D above with medication information)* □ Morphine sulfate controlled release tablets (specifically generic MS Contin) □ Fentanyl transdermal (12, 25, 50, 75, and 100mcg) □ Embeda (morphine sulfate and naltrexone) □ Butrans (buprenorphine) □ Xtampza ER (oxycodone extended-release) □ Tramadol extended release tablets (non-biphasic release tablets) □ Tramadol IR

CANCER/HOSPICE/END-OF-LIFE RELATED PAIN

□ Yes □ No	**Is the patient being treated for cancer related pain?** *If yes, list cancer diagnosis:* *Date of diagnosis:* ***(REQUIRED)***
□ Yes □ No	**Is the patient established on pain therapy with the requested medication for cancer, hospice care, or end-of-life care pain, and the medication is not a new regimen for treatment of cancer, hospice care, or end-of-life care pain?** *If yes, list start date:*

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NON-CANCER/NON-HOSPICE/NON-END-OF-LIFE RELATED PAIN	
□ Yes □ No	**Is the patient being treated for one of the following?** *(If yes, check which applies)* □ Moderate to severe chronic pain that is non-neuropathic □ Moderate to severe 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)*
□ Yes □ No	**Prior to the start of therapy with the long-acting opioid, has the patient failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days?** *(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?**
MULTIPLE CONCURRENT SHORT-ACTING OPIOIDS (>2 OPIATES IN 30 DAYS)	
□ Yes □ No	**Is the requested medication being used to adjust the dose of the drug?**
□ Yes □ No	**Is the requested medication being used in place of a previously prescribed drug, and not in addition to it?**
□ Yes □ No	**Is the requested medication dosage form being used in place of the previously prescribed medication dosage form, and not in addition to it?**
□ Yes □ No	**Does the physician attest they are aware of the multiple short acting opioids prescribed to the patient and feels treatment with all the medications is medically necessary?** *If yes, list rationale:*

QUANTITY LIMIT REQUESTS ***(continues on next page)***

Active Ingredient	FDA Label Max Daily Doses	90 MME (mg/day) (non treatment naïve)
Morphine	None	90mg
Hydromorphone	None	22.5mg
Hydrocodone	None	90mg
Fentanyl transdermal, mcg/hr	None	37.5mcg/hr
Methadone	None	Conversion factor is variable based upon dose
Tapentadol	600mg IR products 500 mg ER Products	225mg
Oxymorphone	None	30mg
Oxycodone	Xtampa Only = 288mg	60mg
Codeine	360mg	600mg
Pentazocine	None	243mg
Tramadol	400mg IR products	900mg
Meperidine	600mg	900mg
Butorphanol nasal	None	12.8mg
Opium	4 suppositories/day Deodorized tincture: 24 mg/day Camphorated tincture: 16 mg/day	90mg
Acetaminophen	4g/day	N/A
Aspirin	2080mg/day	N/A
Ibuprofen	3200mg/day	N/A
Benzhydrocodone	None	73.77mg
Levorphanol	None	8.18mg

□ Yes □ No	**Does the requested medication contain acetaminophen?**
□ Yes □ No	**If the requested drug contains acetaminophen, does the requested dose exceed four grams of acetaminophen per day (4000 mg)?** *List total acetaminophen per day:*

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□ Yes □ No	**Does the requested medication contain ibuprofen?**
□ Yes □ No	**If the requested drug contains ibuprofen, does the requested dose exceed 3200mg of ibuprofen per day?** *List total ibuprofen per day:*
□ Yes □ No	**Does the requested medication contain aspirin?**
□ Yes □ No	**If the requested drug contains aspirin, does the requested dose exceed 2080mg of aspirin per day?** *List total aspirin per day:*
	QUANTITY LIMIT REQUESTS *(continued)*
□ Yes □ No	**Is the requested dose within the FDA maximum dose per day, where an FDA maximum dose per day exists *(see table above)*?**
□ Yes □ No	**Can the requested dose be achieved by moving to a higher strength of the product?**
□ Yes □ No	**Does the prescriber attest that a larger quantity of medication is medically necessary?** *If yes, list reason:*
	CUMULATIVE 90 MED AND/OR CONTINUATION OF THERAPY
□ Yes □ No	**Has the patient tried and failed non-opioid pain medication?** *(If yes, complete Section D above)*
□ Yes □ No	**Has the patient demonstrated meaningful improvement in pain and function?** *If yes, list documented improvement in function or pain score improvement:*
□ 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)*
□ Yes □ No	**Is there rationale for not tapering and discontinuing opioid?** *If yes, list rationale:*

Provider Signature: _____ Date: _____