

**Opioid Products - 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 contains 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:	Policy #:	Group #:

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**

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information about this case, if any:**  
 Please refer to the patient's PDL at [www.uhcprovider.com](http://www.uhcprovider.com) for a list of preferred alternatives

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

Yes  No Does the prescriber attest to ALL of the following: (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 *(Long-acting opioids only)*
- Pain is chronic *(Long-acting opioids only)*
- 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] *(Long-acting opioids only)*
- Pain management is required around the clock with a long-acting opioid *(Long-acting opioids only)*

**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 MME/day, or concurrent use with benzodiazepines. Please refer to Preferred Drug Plan for preferred products.*

**ALL REQUESTS**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient meet any of the following conditions or care instances?</b> <i>(If yes, check all that apply)</i> <input type="checkbox"/> Cancer diagnosis <input type="checkbox"/> End-of-life care <input type="checkbox"/> Hospice care <input type="checkbox"/> Non-cancer pain <input type="checkbox"/> Palliative care <input type="checkbox"/> Post-surgery <input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Requests for short-acting opioids:</b> If the request is for a non-preferred medication, has the patient had a failure, contraindication or intolerance to three preferred short acting opioids? <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Requests for long-acting opioids:</b> <b>Does the patient have a history of failure, contraindication or intolerance to a trial of any of the following?</b> <i>(If yes, check all that apply and complete Section D above)</i> <input type="checkbox"/> Morphine sulfate controlled release tablets (specifically generic MS Contin) <input type="checkbox"/> Zohydro ER <input type="checkbox"/> Fentanyl transdermal (12, 25, 50, 75, and 100mcg) <input type="checkbox"/> Oxymorphone ER non-crush resistant (generic)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of failure, contraindication or intolerance to a trial of tramadol IR?</b> <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Requests for Tramadol 100mg tablets:</b> <b>Is there rationale for needing to use the 100 mg tramadol tablet instead of two 50 mg tramadol tablets?</b> <i>If yes, document rationale:</i>

**SHORT-ACTING OPIOIDS ONLY: OPIOID NAÏVE (< 21 DAYS OF OPIOID THERAPY IN THE LAST 180 DAYS)**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does any of the following apply to the patient?</b> <i>(If yes, check all that applies)</i> <input type="checkbox"/> Traumatic injury <input type="checkbox"/> Post-surgical procedures, excluding dental procedures <input type="checkbox"/> Prescriber attests that the patient has received an opioid within the past 60 days
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the prescriber attest to both of the following?</b> <i>(If yes, check all that apply)</i> <input type="checkbox"/> The information provided is true and accurate to the best of their knowledge and they understand that United HealthCare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided. <input type="checkbox"/> If requested for traumatic injury or post-surgical procedure, prescriber attests that based on injury or surgical procedure performed the member requires greater than a 7 day supply for patients 20 years and older or greater than a 3 day supply for patients under the age of 20 years of short-acting opioid to adequately control pain.



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**SHORT-ACTING OPIOIDS ONLY: OPIOID EXPERIENCED (> 21 DAYS OF OPIOID THERAPY IN THE LAST 180 DAYS)**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have an active diagnosis of cancer requiring pain management or is in hospice care?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the patient already established on chronic opioid therapy prior to this request, so this prescription does not represent a first time move to chronic opioid therapy (Defined as: greater than 21 days with opioid treatment within previous 180 days) AND will clinical documentation showing previous opioid use be submitted along with this fax? <i>DOCUMENTATION REQUIRED</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a reason why the patient requires extended opioid therapy when previously naive to this class of medication or will the provider be submitting chart notes to support the reason? <i>If yes, submit chart notes along with this fax or provide reason:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a signed opioid agreement in place?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the provider checked the Colorado Prescription Drug Monitoring Program (PDMP) [at least once every 3 months]?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the provider performed drug toxicology screens routinely (at least an annual drug screen)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the provider have an active tapering plan for the patient or has provided rationale for continued high dose opioid therapy? <i>If yes, document rationale:</i>

**LONG-ACTING OPIOIDS ONLY: CANCER / HOSPICE / END-OF LIFE RELATED PAIN**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient being treated for cancer related pain? <i>If yes, list cancer diagnosis:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient established on pain therapy with the requested medication for cancer-related pain, hospice related pain, or end-of-life care related pain, and the medication is <u>not</u> a new regimen for treatment of cancer-related pain, hospice, or end-of-life care pain? <i>If yes, document date regimen was started:</i>

**LONG-ACTING OPIOIDS ONLY: NON-CANCER / NON-HOSPICE / NON-END-OF-LIFE RELATED PAIN**

<input type="checkbox"/> Yes <input type="checkbox"/> 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? <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> 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?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient being treated for one of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> Neuropathic pain (e.g., neuralgias, neuropathies, fibromyalgia) <input type="checkbox"/> Non-neuropathic pain
<input type="checkbox"/> Yes <input type="checkbox"/> No	For <u>neuropathic pain requests</u> , unless it is contraindicated, has the patient exhibited an inadequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose? <i>(If yes, complete Section D above)</i> <input type="checkbox"/> Check box if Gabapentin is contraindicated
<input type="checkbox"/> Yes <input type="checkbox"/> No	For <u>neuropathic pain requests</u> , unless it is contraindicated, has the patient exhibited an inadequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose? <i>(If yes, complete Section D above)</i> <input type="checkbox"/> Check box if tricyclic antidepressant is contraindicated

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**EXCEEDING 90 MORPHINE MILLIGRAM EQUIVALENT (MME) CUMULATIVE THRESHOLD**

Please note the plan's quantity limits:

Active Ingredient	FDA Label Max Daily Doses	Max MME (mg/day) (non treatment naïve)
Morphine	None	90mg
Morphine and naltrexone	None	90mg
Hydromorphone	None	22.5mg
Fentanyl transdermal, mcg/hr	None	37.5 mcg/hr
Hydrocodone	None	90mg
Methadone	None	Conversion factor is variable based upon dose
Tapentadol	600mg IR products 500mg ER products	225mg
Oxymorphone	None	30mg
Oxycodone	Xtampza Only =288mg	60mg
Codeine	360mg	600mg
Pentazocine	None	243mg
Tramadol	400mg IR products 300mg ER products	900mg
Meperidine	600mg	900mg
Butorphanol	None	12.86mg
Opium	4 suppositories/day Deodorized Tincture: 24mg/day Camphorated Tincture: 16mg/day	90mg
Benzhydrocodone	None	73.77mg
Levorphenol	None	8.18mg

- Yes  No **Is the requested medication being used for cancer pain or end of life diagnosis (hospice care)?**
- 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 MME been tried and did not adequately control pain? (If yes, complete Section D above)**

**QUANTITY LIMIT**

- Yes  No **Can the requested dose be achieved by moving to a higher strength of the product?**  
*If yes, list reasoning for not switching:*
- Yes  No **Does the requested dose exceed the FDA approved limit or maximum Morphine Milligram Equivalents (MME) per day (see table above)?**  
*If yes, list reason:*

**CONTINUATION OF THERAPY**

- Yes  No **Has the prescriber identified rationale for not tapering and discontinuing opioid?**  
*If yes, document rationale:*
- Yes  No **Has the patient demonstrated meaningful improvement in pain and function?**  
*If yes, document improvement in function or pain score improvement:*

**CONCURRENT USE WITH BENZODIAZEPINE (continued on next page)**

- 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 attest 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 attest to checking the prescription drug monitoring program (PDMP) periodically during treatment?**



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<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have health conditions that pose high risk with this combination therapy (e.g., sleep apnea, renal or hepatic insufficiency, etc.)?</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient taking a skeletal muscle relaxant (e.g., carisoprodol) concurrently?</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Has the patient been screened for substance use disorders?</b>		

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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