UnitedHealthcare Community Plan

Opioid Products - Ohio
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:

UnitedHealthcare Community Plan

Opioid Products - Ohio
PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

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

ALL REQUESTS

□ Yes □ No	**If the request is for a non-preferred medication, has the patient had a failure, contraindication or intolerance to three preferred short acting opioids?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient meet any of the following conditions or care instances?** *(If yes, check all that apply)* □ Hospice member □ End-of-life Care □ Severe burn □ Traumatic crushing of tissue □ Amputation □ Major orthopedic surgery □ Cancer diagnosis □ Palliative care □ Non-cancer pain □ Sickle cell diagnosis □ Attestation from the provider that the member is not opioid-naïve (check to attest)
□ 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)* □ Morphine sulfate controlled release tablets (specifically generic MS Contin) □ Zohydro ER □ Fentanyl transdermal (12, 25, 50, 75, and 100mcg) □ Oxymorphone ER non-crush resistant (generic)
□ 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)*

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 related pain, hospice related pain, or end-of-life care related pain, and the medication is not a new regimen for treatment of cancer related pain, hospice, or end-of-life care pain?** *If yes, list start date:*

NON-CANCER / NON-HOSPICE / NON-END-OF-LIFE CARE PAIN ***(continued on next page)***

□ 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	**Unless it is contraindicated, has the patient exhibited an inadequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose?** *(If yes, complete Section D above)*

UnitedHealthcare Community Plan

Opioid Products - Ohio
PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**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?** *(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?**

GREATER THAN 7 DAYS SUPPLY / EXCEEDS 30MME PER PRODUCT PER DAY

□ Yes □ No	**Are non-pharmacologic treatment and/or non-opioid analgesics ineffective or contraindicated?**
□ Yes □ No	**Does the patient have a diagnosis of somatic or visceral type pain?**
□ Yes □ No	**Have the benefits and risks of opioid therapy been discussed with the patient?**
□ Yes □ No	**Has the prescriber attested that he/she has checked the Ohio Automated Rx Reporting System (OARRS)?**

QUANTITY LIMIT & EXCEEDING 90 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		12.8mg
Opium	4 suppositories/day Deodorized Tincture: 24mg/day Camphorated Tincture: 16mg/day	90mg

□ Yes □ No	**Has the patient tried and failed non-opioid pain medication?** *(If yes, complete Section D above)*
□ 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	**Have opioid medication doses of less than 90 MME been tried and did not adequately control pain?** *(If yes, complete Section D above)*

UnitedHealthcare Community Plan

Opioid Products - Ohio
PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**Does the request dose exceed the FDA approved limit or maximum Morphine Milligram Equivalents per day (MME)?** *If yes, list reason:*
CONTINUATION OF THERAPY	
□ Yes □ No	**Has the patient demonstrated meaningful improvement in pain and function?** *If yes, list improvement in function or pain score improvement:*
□ Yes □ No	**Has the prescriber identified rationale for not tapering and discontinuing opioid?** *If yes, list rationale:*

Physician Signature: _____ Date: _____