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 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 at www.uhcprovider.com 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	
□ **Yes** □ **No**	**Is the patient receiving the requested medication to treat any of the following?** *(If yes, check which applies)* □ Amputation □ Cancer pain □ Catastrophic injury □ End-of-life/hospice care □ Major orthopedic surgery □ Palliative care □ Severe burn □ Sickle cell □ Traumatic crushing of tissue
□ **Yes** □ **No**	**Has the patient had an inadequate clinical response to a 7-day trial of one preferred product?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is the patient unable to be changed to a preferred medication due to any of the following?** *(If yes, check which applies and complete Section D above)* □ Patient has an allergy to TWO unrelated preferred medications □ Patient has a contraindication to, or drug-to-drug interaction with, preferred medications □ Patient has a history of unacceptable/toxic side effects to preferred medications
□ **Yes** □ **No**	**For brand requests has the patient failed the generic product (if covered by the state)?** *(If yes, complete Section D above)*
LONG-ACTING OPIOIDS	
□ **Yes** □ **No**	**Is there documentation of a treatment plan including any of the following?** *(If yes, check which applies)* □ Risk assessment □ Substance abuse history □ Concurrent therapies
□ **Yes** □ **No**	**Was the Ohio Automated Rx Reporting System (OARRS) checked within 7 days prior to initiating long-acting therapy?**
□ **Yes** □ **No**	**Does the patient have documentation of pain and function scores at each visit?**
□ **Yes** □ **No**	**Has patient's baseline urine drug test been submitted and treatment plan includes requirements for random urine screens?** *(DOCUMENTATION REQUIRED)*
□ **Yes** □ **No**	**Is the patient's opioid contract in place and been submitted?** *(DOCUMENTATION REQUIRED)*
□ **Yes** □ **No**	**Does that patient have documented failure of both non-opioid pharmacologic and non-pharmacologic treatments?**
□ **Yes** □ **No**	**Does the patient have a history of short-acting opioids for greater than or equal to 60 days?**
ABSTRAL, BRAND ACTIQ, GENERIC FENTANYL LOZENGE, BRAND FENTORA, GENERIC FENTANYL CITRATE BUCCAL TABLETS, SUBSYS	
□ **Yes** □ **No**	**Is the prescription from an oncologist or pain specialist?**
□ **Yes** □ **No**	**Is the patient concurrently taking a long-acting opioid at therapeutic dose (ANY of the following for greater than or equal to 1 week without adequate pain relief)?** *(If yes, check which applies)* □ Greater than or equal to 60 milligrams (mg) oral morphine/day □ Greater than or equal to 25 micrograms (mcg)/hour transdermal fentanyl □ Greater than or equal to 30 mg oral oxycodone/day □ Greater than or equal to 8 mg oral hydromorphone/day □ Greater than or equal to 25 mg oral oxymorphone/day □ Equianalgesic dose of another opioid
QUANTITY LIMIT – NEW START – SHORT-ACTING OPIOID (cont'd on the next page)	
□ **Yes** □ **No**	**Has the patient had a trial and failure of non-pharmacologic treatments and/or non-opioid analgesics or are non-pharmacologic treatments and/or non-opioid analgesics are ineffective or contraindicated?**

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□ Yes □ No	**Does the patient have a diagnosis of somatic pain?**
□ Yes □ No	**Have the benefits and risks of opioid therapy been discussed with the patient?**
□ Yes □ No	**Has the prescriber checked the Ohio Automated Rx Reporting System (OARRS)?**
□ Yes □ No	**Is there attestation that patient is not opioid naïve based on patient having been on a higher dose in the hospital?**
QUANTITY LIMIT – EXCEEDING CUMULATIVE 30 MME PER PRODUCT OR 90 MME LIMIT	
□ Yes □ No	**Does the prescriber indicate the requested dose or escalation of dose is likely to result in improved function and pain control?**
□ Yes □ No	**Are cumulative doses greater than 100 morphine equivalent dose (MED) made in consultation with pain specialist or anesthesiologist?**
CONTINUATION OF THERAPY - LONG-ACTING OPIOIDS	
□ Yes □ No	**Is there a current treatment plan?**
□ Yes □ No	**Has the patient demonstrated adherence to treatment plan through progress notes including pain and function scores and random urine screens results reviewed and concerns addressed, no serious adverse outcomes observed?**

Provider Signature: _____ Date: _____