UnitedHealthcare Community Plan

Opioid Dependence Treatments - Pennsylvania
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 there documentation that the prescriber or the prescriber's delegate conducted a search of the Pennsylvania Prescription Drug Monitoring Program for the beneficiary's controlled substance prescription history?**
BUNAVAIL FILM / BRAND SUBOXONE SL FILM / ZUBSOLV SL TAB	
□ Yes □ No	**Does the patient have a history of therapeutic failure, contraindication, or intolerance of the preferred oral buprenorphine opioid dependence treatments?** *(If yes, complete Section D above)*
BUPRENORPHINE SL TAB	
□ Yes □ No	**Is the requested medication prescribed for induction therapy?**
□ Yes □ No	**Is the patient pregnant?**
□ Yes □ No	**Is the patient breastfeeding?**
CATAPRES TAB / LUCEMYRA	
□ Yes □ No	**Does the patient have a history of therapeutic failure, contraindication, or intolerance of the preferred alpha2-adrenergic agonist opioid dependence treatments?** *(If yes, complete Section D above)*
USED IN COMBINATION WITH A BENZODIAZEPINE OR CENTRAL NERVOUS SYSTEM (CNS) DEPRESSANT	
□ Yes □ No	**Is there documentation the patient is being counseled about the serious risks of combined use?**
□ Yes □ No	**Is there documentation of a tapering plan for the benzodiazepine or CNS depressant?**
□ Yes □ No	**If the patient is receiving a benzodiazepine or other CNS depressant for anxiety or insomnia, is there documentation of verification of the diagnosis and consideration of other treatment options for these conditions by the prescriber?**
□ Yes □ No	**Is there documentation the concomitant use is medically necessary for the patient?**
□ Yes □ No	**Is there documentation of the patient's urine or blood drug screening?**
QUANTITY LIMIT	
□ Yes □ No	**Is there documentation of an evaluation by a licensed Drug & Alcohol (D&A) provider or a Single County Authority to determine the recommended level of care?**
□ Yes □ No	**Is there documentation of the patient's participation with a licensed D&A or behavioral health provider at the recommended level of care until successful completion of the program?**
□ Yes □ No	**Upon successful completion of the program, is the patient participating in a substance abuse or behavioral health counseling or treatment program or an addictions recovery program?**
□ Yes □ No	**Does the patient demonstrate compliance with oral buprenorphine therapy as documented by a recent urine drug screen testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, tramadol, and carisoprodol) that is any of the following?** *(If yes, check which applies)* □ Positive for buprenorphine and norbuprenorphine □ Consistent with prescribed controlled substances

Provider Signature: _____ **Date:** _____