UnitedHealthcare Community Plan

Opioid Products - 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**	**Does the patient have any of the following diagnoses?** *(If yes, check which applies)* □ Active cancer □ Sickle cell with crisis □ Neonatal abstinence syndrome □ Receiving palliative care or hospice services □ Pain
□ **Yes** □ **No**	**Does the patient have a documentation of pain that is any of the following?** *(If yes, check which applies)* □ Caused by a medical condition □ Not neuropathic or migraine in type □ Pain is severe, as documented by a pain assessment tool measurement (e.g., a numeric or visual analog scale)
□ **Yes** □ **No**	**Is there documentation of the anticipated duration of therapy?** *If yes, list duration:*
□ **Yes** □ **No**	**Is there documentation the patient has had therapeutic failure, contraindication, or intolerance to any of the following pain management modalities?** *(If yes, check which applies)* □ Non-pharmacologic techniques (i.e., behavioral, cognitive, physical, and/or supportive therapies) □ Non-opioid analgesics (e.g., acetaminophen, NSAIDs) *(complete Section D above)*
□ **Yes** □ **No**	**Is there documentation that the requested medication will be used in combination with tolerated non-pharmacologic therapy and non-opioid pharmacologic therapy?**
□ **Yes** □ **No**	**Is there documentation the patient has had a trial of a short acting opioid analgesic (see Preferred Drug List "Analgesics, Opioid Short Acting" section)?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is the patient opioid-tolerant [defined as taking at least morphine 60 mg (milligrams)/day, transdermal fentanyl 25 mcg (micrograms)/hour, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for one week or longer]?**
□ **Yes** □ **No**	**Is there documentation any of the following received education on the potential adverse effects of opioid analgesics, including the risk for misuse, abuse, and addiction?** *(If yes, check which applies)* □ Patient □ Parent/guardian (if patient is under 21 years of age)
□ **Yes** □ **No**	**Was the patient assessed for potential risk of misuse, abuse, or addiction based on family and social history obtained by the prescribing provider?**
□ **Yes** □ **No**	**Was the patient evaluated for risk factors for opioid-related harm, and if the patient was identified at high risk for opioid-related harm, the prescriber considered prescribing naloxone?**
□ **Yes** □ **No**	**Was the patient assessed for recent use (within the past 60 days) of an opioid?**
□ **Yes** □ **No**	**Is the patient not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined medically necessary?**
□ **Yes** □ **No**	**Does the patient have a recent urine drug screen (UDS) (including testing for licit and illicit drugs with the potential for abuse; must include specific testing for oxycodone, fentanyl, tramadol, and carisoprodol) that is consistent with prescribed controlled substances?**
□ **Yes** □ **No**	**Does the patient have a documented history of intolerance, contraindication to, or therapeutic failure of any preferred medication (see Preferred Drug List "Analgesics, Opioid Long Acting" section*)?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Does the patient have a history of a contraindication, intolerance, or therapeutic failure of at least three unrelated (different opioid ingredient) preferred analgesics, opioid short acting medication (single entity or combination products)?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Does the prescribing provider confirm that he/she, or the prescribing provider's delegate, conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the patient's controlled substance prescription history before the requested medication was prescribed?**

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□ Yes □ No	**For a patient with concurrent prescription for a buprenorphine agent indicated for the treatment of opioid dependence or naltrexone for extended-release injectable suspension (Vivitrol), does any of the following apply to the patient?** *(If yes, check which applies)* □ Both of the prescriptions are written by the same prescriber or, if written by different prescribers, all prescribers are aware of the other prescription(s) □ The patient has an acute need for therapy with an analgesic, opioid short acting and the other therapy will be suspended during the treatment for acute pain
CANCER	
□ Yes □ No	**Is the prescriber an American Board of Medical Specialties (ABMS) certified oncologist or pain specialist?**
BUTORPHANOL TARTRATE NASAL SOLUTION	
□ Yes □ No	**Does the patient have a diagnosis of migraine?**
□ Yes □ No	**Is the requested medication prescribed by a neurologist or pain medication specialist?**
□ Yes □ No	**Does the patient have a history of contraindication, intolerance, or therapeutic failure of the triptans for abortive therapy?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have a history of a contraindication, intolerance, or therapeutic failure of any of the following preventive therapies?** *(If yes, check which applies and complete Section D above)* □ Beta blockers □ Calcium channel blockers □ Anticonvulsants □ Selective serotonin reuptake inhibitor (SSRI) Antidepressants □ Tri-cyclic antidepressants □ Non-steroidal anti-inflammatories (NSAIDs)
QUANTITY LIMIT	
□ Yes □ No	**Does the patient have one of the following?** *(If yes, check which applies)* □ Moderate pain □ Severe pain
□ Yes □ No	**Is the requested medication being prescribed by an appropriate specialist or in consultation with an appropriate specialist?**
□ Yes □ No	**Is the patient inadequately controlled at the current quantity limit?**
□ Yes □ No	**Is the pain inadequately controlled by other analgesics, opioid short acting or the patient has a history of a contraindication, or adverse reaction to alternative analgesics, opioid short acting?**
□ Yes □ No	**Would the patient be more appropriately pain controlled by initiating or adjusting the dose of an analgesic, opioid long acting?**
□ Yes □ No	**For doses that exceed the FDA (Food and Drug Administration)-approved starting dose, is there documentation demonstrating an appropriate upward titration or an appropriate conversion from other opioid-containing medications?** *If yes, please document:*
CONTINUATION OF THERAPY	
□ Yes □ No	**Has the patient experienced an improvement in pain control and level of functioning while on the requested agent?**
□ Yes □ No	**Is the patient being monitored by the prescriber for adverse events and warning signs for serious problems, such as overdose and opioid use disorder?**
□ Yes □ No	**Does the patient have a urine drug screen (including testing for licit and illicit drugs with the potential for abuse; and specific testing for oxycodone, fentanyl, tramadol, and carisoprodol) that is consistent with prescribed controlled substances at least once a year?** *(If so, check which applies)* □ Every 3 months □ Every 12 months

Provider Signature: _____ **Date:** _____