

Opioid Products – Rhode Island 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:

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

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the prescriber attest to ALL of the following: (REQUIRED)
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- 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 MED/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	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)
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient meet any of the following conditions or care instances? (If yes, check all that apply) <input type="checkbox"/> Hospice member <input type="checkbox"/> Cancer diagnosis <input type="checkbox"/> Post-surgery <input type="checkbox"/> End-of-life Care <input type="checkbox"/> Non-cancer pain <input type="checkbox"/> Sickle cell diagnosis <input type="checkbox"/> Attestation from the provider that the member is not opioid-naïve (check to attest)
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<input type="checkbox"/> Yes <input type="checkbox"/> 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) <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)
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of failure, contraindication or intolerance to a trial of tramadol IR? (If yes, complete Section D above)
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CANCER / HOSPICE / END-OF-LIFE RELATED PAIN

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient being treated for cancer related pain? If yes, list cancer diagnosis: _____ Date of diagnosis: _____ (REQUIRED)
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<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 not a new regimen for treatment of cancer related pain, hospice, or end-of-life care pain? If yes, list start date: _____
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NON-CANCER / NON-HOSPICE / NON-END-OF-LIFE CARE PAIN (continued on next page)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient being treated for one of the following? (If yes, check which applies) <input type="checkbox"/> Moderate to severe chronic pain that is non-neuropathic <input type="checkbox"/> Moderate to severe neuropathic pain (e.g. neuralgias, neuropathies, fibromyalgia)
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<input type="checkbox"/> Yes <input type="checkbox"/> 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)
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<input type="checkbox"/> Yes <input type="checkbox"/> 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)
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<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? (If yes, complete Section D above)
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Member First name:	Member Last name:	Member DOB:
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<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?
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QUANTITY LIMIT & EXCEEDING 90 MED CUMULATIVE THRESHOLD

Please note the plan's quantity limits:

Active Ingredient	FDA Label Max Daily Doses	Max MED (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	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
Benzhydrocodone	None	73.77mg
Levorphanol	None	8.18mg

<input type="checkbox"/> Yes <input type="checkbox"/> No	Can the requested dose be achieved by moving to a higher strength of the product? <i>If yes, list reasoning for not switching:</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there a reason why a greater quantity of medication is required to treat the patient's condition? <i>If yes, list reason:</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the request dose exceed the FDA approved limit or maximum Morphine Equivalents per day (MED)? <i>If yes, list reason:</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient tried and failed non-opioid pain medication? <i>(If yes, complete Section D above)</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Have opioid medication doses of less than 90 MED been tried and did not adequately control pain? <i>(If yes, complete Section D above)</i>
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CONTINUATION OF THERAPY

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient demonstrated meaningful improvement in pain and function? <i>If yes, list improvement in function or pain score improvement:</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the prescriber identified rationale for not tapering and discontinuing opioid? <i>If yes, list rationale:</i>
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Physician Signature: _____ **Date:** _____