UnitedHealthcare Community Plan

Opioid Products - Texas
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:
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

□ Yes □ No	**Does the prescriber attest to ALL of the following? (REQUIRED)**

- 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.

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
□ Yes □ No	**Does the patient meet any of the following conditions or care instances?** *(If yes, check which applies)* □ Cancer diagnosis □ End-of-life care □ Hospice care □ Non-cancer pain □ Palliative care □ Sickle cell anemia □ Other. Please specify: _____
□ Yes □ No	**Is the patient a resident of a long-term care facility or another facility for which residents receive opioid substitution therapy for treatment of opioid use disorder (OUD)?**
□ Yes □ No	**Has the patient demonstrated failure to at least ONE of the preferred formulary/PDL (preferred drug list) alternatives for the given diagnosis within the last 180 days?** *(If yes, complete Section D above)*
□ Yes □ No	**Has the patient demonstrated history of contraindication, intolerance, or allergy to at least ONE of the preferred formulary/PDL alternatives for the given diagnosis?** *(If yes, complete Section D above)*
□ Yes □ No	**Is the requested medication being used for the treatment of stage-four advanced, metastatic cancer and associated conditions?**
	OPIOID-NAÏVE PATIENTS
□ Yes □ No	**Has the patient taken opioids for a duration of more than 7 days in the prior 60-day period?**
□ Yes □ No	**Does the prescriber attest that the patient has received an opioid for greater than 7 days in the prior 60-day period?**
□ Yes □ No	**Does the patient have any of the following?** *(If yes, check which applies)* □ Traumatic injury □ Post-surgical procedures, excluding dental procedures
□ Yes □ No	**If yes to the above, does the prescriber attest that based on injury or surgical procedure performed, the patient requires greater than a 10-day supply of short-acting opioid to adequately control pain?**
	QUANTITY LIMIT & EXCEEDING 90 MME CUMULATIVE THRESHOLD
□ Yes □ No	**Does the patient have any of the following?** *(If yes, check which applies)* □ An end of life diagnosis (hospice care) □ End-of-life related pain □ Sickle cell □ Cancer pain □ Hospice related pain
□ 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	**Does the requested dose exceed the FDA approved opioid maximum dose per day, where an FDA maximum dose per day exists (see table below)?** *If yes, list reason:*
□ Yes □ No	**Has the patient tried and failed non-opioid pain medication?** *(If yes, complete Section D above)*
□ 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)*

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CONTINUATION OF THERAPY

□ Yes □ No	**Has the prescriber identified rationale for not tapering and discontinuing opioid?** *If yes, document rationale:*
□ Yes □ No	**Has the patient demonstrated meaningful improvement in pain and function?** *If yes, document improvement in function or pain score improvement:*

Active Ingredient	FDA Label Max Daily Doses	49 MME Equivalent (mg/day)	90MME Equivalent (mg/day) (non-treatment naïve)*
Morphine	None	49mg	90mg
Buprenorphine	1800mcg		3000mcg
Buprenorphine transdermal patch	20mcg/hr		50 mcg/hr
Morphine and naltrexone	None		90mg
Hydromorphone	None	12.25mg	22.5mg
Fentanyl transdermal, mcg/hr	None		37.5 mcg/hr
Hydrocodone	None	49mg	90mg
Methadone	None		Conversion factor is variable based upon dose
Tapentadol	600mg IR products 500mg ER products	122.5mg	225mg
Oxymorphone	None	16mg	30mg
Oxycodone	None	33mg	60mg
Codeine	360mg	327mg	600mg
Pentazocine	None	132mg	243mg
Tramadol	400mg IR products 300mg ER products	490mg	900mg
Meperidine	600mg	490mg	900mg
Butorphanol	None	7mg	12.86mg
Opium	4 suppositories/day Deodorized Tincture: 24mg/day Camphorated Tincture: 16mg/day	49mg	90mg

*Doses are not considered equianalgesic and table does not represent a dose conversion chart.

Physician Signature: _____ Date: _____