UnitedHealthcare Community Plan

Methadone – Virginia
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 and Explanation of why preferred medications would not meet the patient's needs

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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?** *(If yes, signature required)*

- **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 plan with goals that addresses benefits and harm has been established with the patient**
- **Established expected outcome and improvement in both pain relief and function or just pain relief as well as limitations (i.e., Function may improve yet pain persist OR pain may never be totally eliminated)**
- **Established goals for monitoring progress toward patient-centered functional goals; e.g., walking the dog or walking around the block, returning to part-time work, attending family sports or recreational activities, etc.**
- **Goals for pain and function, how opioid therapy will be evaluated for effectiveness and the potential need to discontinue if not effective.**
- **Emphasize serious adverse effects of opioids (including fatal respiratory depression and opioid use disorder, OR alter the ability to safely operate a vehicle)**
- **Emphasize common side effects of opioids (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, withdrawal)**

Prescriber's Signature: _____ ***Date:*** _____

ALL REQUESTS	
□ Yes □ No	**Does the patient have any of the following diagnoses?** □ Metastatic neoplasia □ Sickle cell □ Chronic severe pain
□ Yes □ No	**Is the requested medication being prescribed by one of the following specialists?** *(If yes, check which applies)* □ Oncologist □ Sickle cell specialist □ Chronic pain specialist □ Palliative care
□ Yes □ No	**Does the patient have a contraindication to all other preferred and non-preferred long acting opioids, along with submission of MedWatch form documentation?** *(DOCUMENTATION REQUIRED)* *If yes, list contraindications:*
□ Yes □ No	**Does the patient have a history of or ever received treatment for drug dependency or drug abuse?**
□ Yes □ No	**Has the prescriber checked the PMP (document date accessed) on the date of this request to determine whether the patient is receiving opioid dosages or dangerous combinations (such as opioids and benzodiazepines) that put him or her at high risk for fatal overdose?** *If yes, list date checked:*
What is the patient's total morphine milligrams equivalents (MME) from the PMP website? _____ **per day**	
□ Yes □ No	**Does the prescriber attest to any of the following?** *(If yes, check which applies)* □ For an MME of 51-90 MME/day, the prescriber attests that he/she considered offering a prescription for naloxone and overdose prevention education □ For an MME > 90MME/day, the prescriber attest that he/she considered offering prescription for naloxone, providing overdose prevention education, and consulting with a pain specialist
What is the date of the patient's last opioid prescription from the PMP?	
What is the date of the patient's last benzodiazepine prescription from the PMP?	
□ Yes □ No	**Has the prescriber counseled the patient of the risks associated with combined use of benzodiazepines and opioids?**
□ Yes □ No	**Has an annual presumptive urine drug screen (UDS) which checks for the prescribed drug and a minimum of 10 substances including heroin, prescription opioids, cocaine, marijuana, benzodiazepines, amphetamines, and metabolites been completed and a copy submitted?** *(DOCUMENTATION REQUIRED)*
MORPHINE MILLIGRAMS EQUIVALENT (MME) SECTION (cont'd on the next page)	
□ Yes □ No	**Does the patient have chronic, moderate to severe pain or severe post-operative pain?**

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□ Yes □ No	**Does the prescriber attest to the following:** - That he/she will be managing the patient's opioid therapy long term - Has reviewed the Virginia BOM Regulations for Opioid Prescribing - Acknowledges the warnings associated with high dose opioid therapy including fatal overdose - That therapy is medically necessary for this patient
□ Yes □ No	**If patient is female between 18-45 years old, has the prescriber discussed risk of becoming pregnant while receiving opioids, including the risk of neonatal opioid withdrawal syndrome and offered access to contraceptive services when necessary?**
□ Yes □ No	**Has the prescriber ordered and reviewed a urine drug screen (UDS) or serum medication level at least every 3 months for the first year of treatment and at least every 6 months thereafter to ensure adherence?**
□ Yes □ No	**Has naloxone been prescribed for the patient?**
BUPRENORPHINE PLUS OPIOID USE SECTION	
□ Yes □ No	**Does the provider attest to the following:** • **there are extenuating circumstances necessitating the need to co-prescribe these medications** • **there is a documented tapering plan to achieve the lowest effective doses of these medications** *If yes, list extenuating circumstances and taper plan:*
What is the date of the patient's last buprenorphine MAT prescription from the PMP?	

Physician Signature: _____ **Date:** _____

Patient Utilization Management and Safety (PUMS) Program

UnitedHealthcare Community Plan of Virginia has a Patient Utilization Management & Safety (PUMS) program in place. The program makes sure that members are getting the proper health care, especially when it comes to patient safety.

PUMS Program Goal:
PUMS deals with prescription drugs as well as other kinds of health care, making certain the member is getting treatment that is proper and safe. UnitedHealthcare Community Plan of Virginia's clinical staff reviews our members' use of health care services to see whether they should be in the PUMS program. For members in the PUMS program, UnitedHealthcare Community Plan of Virginia takes extra steps to make sure they use services safely.

Being considered for PUMS does NOT mean a member has done anything wrong.
For any member who may be at risk for unsafe services, UnitedHealthcare Community Plan of Virginia must review whether the member should be in the PUMS program. In cases involving buprenorphine use, the member will automatically be in the PUMS program.

How Might PUMS Change a Member's Care?
UnitedHealthcare Community Plan of Virginia may offer case management services. UnitedHealthcare Community Plan of Virginia could set a single doctor for controlled substances to see the member, or a single pharmacy to provide controlled substance prescription drugs.

PUMS Member Rights: UnitedHealthcare Community Plan of Virginia will send every PUMS member a letter about the program. The letter will make clear how the member can get emergency care. The letter will also tell them how they can appeal being placed in the PUMS program.

PLEASE NOTE: UnitedHealthcare Community Plan of Virginia doctors and pharmacists now use the Prescription Monitoring Program (PMP). The PMP helps them make sure that prescription drugs are used safely. Among other Patient Utilization Management & Safety (PUMS) triggers we review patients who have:

High Average Daily Dose: ≥ 120 cumulative morphine milligram equivalents (MME) per day over the past 90 days.

And/or

Concurrent use of Opioids and Benzodiazepines – at least 1 Opioid claim and 14 day supply of Benzo (in any order)

Our approach is to work collaboratively with patients and providers to ensure safe and appropriate use of controlled substances. We utilize and promote:

A) PMP Checks
B) Letter to Doctor & Member
C) Soft and Hard Pharmacy edits for Benzodiazepine and Opioid utilization
D) Following CDC Opioid Guidelines
E) Case Management as appropriate

We greatly appreciate your collaboration and UnitedHealthcare Community Plan of Virginia service to our members. As part of our PUMS safety review we hope to collaborate with you for complete patient information with the goal of validating safe and appropriate controlled substance use and coordinated patient care.

RESPECTFULLY,
UnitedHealthcare Community Plan of Virginia CLINICAL STAFF