UnitedHealthcare Community Plan

Opioid Products - 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 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

□ Yes □ No	**Does the prescriber attest to the following? (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
	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 MME/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?** *(If yes, check which applies)* □ Patient is being treated for active cancer related pain □ Patient is established on pain therapy with the requested medication for cancer-related pain *List date regimen was started:*_____ □ Receiving palliative care □ Receiving hospice care or end of life care □ Patient is in remission from cancer and the prescriber is safely weaning patients off of opioids with a tapering plan □ Patient is in a long term care (LTC) facility □ Patient has sickle cell disease □ Patient has chronic moderate to severe pain □ Patient has severe post-operative pain □ Patient has breakthrough cancer pain
□ 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 prior to initiating treatment with the requested medication?**
□ 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	**Does the patient have a history of contraindication, drug-drug interaction with, or toxic side effects that cause immediate or long-term damage from any preferred products?** *(If yes, complete Section D above)*
	Document the patient's total morphine milligrams equivalents (MME) from the PMP website:
	Document the patient's active daily morphine milligrams equivalents (MME) from the PMP:
	Document the date of the patient's last opioid prescription from the PMP:
	Document the date of the patient's last benzodiazepine prescription from the PMP:
	Document the date of the patient's last buprenorphine MAT prescription from the PMP:
	CANCER / PALLIATIVE CARE / HOSPICE / CANCER WEAN / LTC
□ Yes □ No	**Is the patient established on pain therapy with the requested medication for cancer-related pain or palliative care pain, and the medication is not a new regimen for treatment of cancer-related pain or palliative care pain?** *If yes, list date started:*
□ Yes □ No	**Does the patient have a history of contraindication, drug-drug interaction with, or toxic side effects that cause immediate or long-term damage from any of the following?** *(If yes, check which applies and complete Section D above)* □ Morphine sulfate controlled release tablets (specifically generic MS Contin) □ Preferred fentanyl transdermal (12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg) □ Butrans transdermal (brand) □ Buprenorphine (generic Butrans) patches

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NON-CANCER / NON-PALLIATIVE CARE / NON-HOSPICE / NON-CANCER WEAN / NON-LTC	
□ **Yes** □ **No**	**Does the patient require continuous around-the-clock analgesia therapy?**
□ **Yes** □ **No**	**Has naloxone been prescribed for patients with any of the following risk factors?** *(If yes, check which applies. If no, list reason below)* □ Substance use disorder □ Doses in excess of 50 MME/day □ Concomitant antipsychotics □ Concomitant pregabalin □ Concomitant "Z" drugs (eszopiclone, zolpidem, or zaleplon) □ Concomitant benzodiazepine use □ Concomitant antihistamines □ Concomitant gabapentin □ Concomitant tricyclic antidepressants *List reason:*
□ **Yes** □ **No**	**Does the prescriber attest a treatment plan with goals that addresses benefits and harm has been established with the patient?**
□ **Yes** □ **No**	**Has the patient tried any of the following?** *(If yes, check which applies and complete Section D above)* □ Baclofen □ Duloxetine □ Lidocaine 5 percent patch □ NSAIDs (oral) □ Tricyclic antidepressants □ Cognitive behavioral therapy □ Gabapentin □ Capsaicin gel □ Physical therapy
BUPRENORPHINE PLUS OPIOID USE	
□ **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:*
MORPHINE MILLIGRAM EQUIVALENT (MME)	
□ **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**	**Has naloxone been prescribed for the patient?**

Provider Signature: _____ **Date:** _____