UnitedHealthcare Community Plan

Methadone - Washington
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

The following information below MUST be included upon submission:
□ Medical records that support the medical need to exceed 200 MME per day

□ Yes □ No	**Does the patient have one of the following diagnoses?** *(If yes, check which applies)* □ Active cancer pain, hospice, palliative care or end-of-life □ Chronic non-cancer pain

CHRONIC NON-CANCER PAIN

□ Yes □ No	**Does the patient have recent history of failure within the last 12 months, contraindication, or intolerable adverse effects to ALL generic long-acting opioids?** *(If yes, complete Section D above)*
□ Yes □ No	**Is there documented clinical benefit at previous doses and clear clinical rationale that the patient is likely to benefit from further dose increases?** *If yes, list rationale:*

GREATER THAN 120 MME

□ Yes □ No	**Does the prescriber attest to all of the following?**

- **Patient has received an opioid prescription written by a provider in an emergency room setting or by a prescriber in an urgent care facility associated with a hospital for no more than a 10-day supply (may only be authorized for 2 times within a 12-month period); OR**
- **Patient is currently on chronic opioid therapy and requires an escalation in opioid dosage that exceeds 120 MME per day but less than 200 MME per day, for no more than 42 days in a 90 day period; OR**
- **Patient is following a tapering schedule with a starting dose > 120 MME per day but < 200 MME per day; OR**
- **Patient has a medically necessary need to exceed 120 MME per day documented in the medical record; AND**
- **The prescriber is a pain specialist as defined in:**
  - **WAC 246-817-965;**
  - **WAC 246-840-493;**
  - **WAC 246-853-750**
  - **WAC 246-919-945;**
  - **WAC 246-922-750; OR**
- **The prescriber that has successfully completed a minimum of twelve continuing education hours on chronic pain management within the previous four years. At least two of these hours must be dedicated to substance use disorders; OR**
- **The prescriber is a pain management practitioner working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; OR**
- **The prescriber has a minimum of three years of clinical experience in a chronic pain management setting, and at least thirty percent of their current practice is the direct provision of pain management care; OR**
- **The prescriber has obtained a consultation with a pain management specialist via one of the following:**
  - **An office visit with patient and pain management specialist; OR**
  - **Telephone, electronic, or in-person consultation between the pain management specialist and the prescriber; OR**
  - **An audio-visual evaluation conducted by the pain management specialist remotely where the patient is present with either the physician or a licensed health care practitioner designated by the physician or the pain management specialist**

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.

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CONTINUATION OF THERAPY	
□ Yes □ No	Does the patient demonstrate clinically meaningful improvement in pain and/or function?

Provider Signature: _____ Date: _____