UnitedHealthcare Community Plan

Short-Acting Opioids - Michigan
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	
□ **Yes** □ **No**	**Has the patient had a therapeutic failure of <u>one week</u> each with <u>two</u> preferred medication?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Does the patient have an allergy to all the preferred medications?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Does the patient have a contraindication or drug to drug interaction with all the preferred medications?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Does the patient have a history of unacceptable side effects with all the preferred medications?** *(If yes, complete Section D above)*
BRAND ACTIQ / BRAND FENTORA / FENTANYL CITRATE BUCCAL TABLETS	
□ **Yes** □ **No**	**Is the requested medication being used for the management of breakthrough cancer pain in a patient established on immediate release and long-acting opioid therapy?**
□ **Yes** □ **No**	**Are the requests for controlled substances under the name and ID of the prescribing physician?**
□ **Yes** □ **No**	**Is the requested medication prescribed by a physician who is experienced in the use of Schedule II opioids?**
□ **Yes** □ **No**	**Is the current dosage regimen of the long-acting and regularly prescribed immediate-release narcotic maximally optimized?**
□ **Yes** □ **No**	**Is the requested medication being used with other <u>inducers</u> of cytochrome P450 concomitantly?**
□ **Yes** □ **No**	**Is the requested medication being used with other <u>inhibitors</u> of cytochrome P450 concomitantly?**
QUANTITY LIMIT **Requests for more than a 7-day supply when the patient is opioid naïve (defined as not having filled an opioid in the past 60 days)**	
□ **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 □ Palliative care □ Sickle cell anemia
□ **Yes** □ **No**	**Does any of the following apply to the patient?** *(If yes, check all that apply)* □ Traumatic injury □ Post-surgical procedures, excluding dental procedures □ Prescriber attests that the patient has received an opioid within the past 60 days
□ **Yes** □ **No**	**Does the prescriber attests to both of the following?** *(If yes, check all that apply)* □ The information provided is true and accurate to the best of their knowledge and they understand that United HealthCare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided. □ If requested for traumatic injury or post-surgical procedure, prescriber attests that based on injury or surgical procedure performed the member requires greater than a 7 day supply of short-acting opioid to adequately control pain.

Provider Signature: _____ **Date:** _____