UnitedHealthcare Community Plan

Opioid Products - Arizona
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 for a list of preferred alternatives

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Clinical and Drug Specific Information

□ Yes □ No	**Does the prescriber attest to <u>ALL</u> of the following?** *(If yes, signature required)*

- **The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed and the medical information necessary to verify the accuracy of the information provided may be requested**
- **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**
- **Pain is moderate to severe and expected to persist for an extended period of time [chronic]** *(Long-acting opioids only)*
- **Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time)** *[Long-acting opioids only]*
- **Pain management is required around the clock with a long-acting opioid** *(Long-acting opioids only)*

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 have any of the following?** *(If yes, check which applies)* □ Active oncology diagnosis □ Children on opioid wean at time of hospital discharge □ Chronic conditions for which the provider has received prior authorization approval □ End-of-life care (other than hospice) □ Hospice care □ Palliative care □ Post-surgical procedures □ Skilled nursing facility care □ Traumatic injury, including burns and excluding post-surgical procedures
□ Yes □ No	**<u>Requests for short-acting opioids:</u>** **Does the patient have a history of failure, contraindication or intolerance to a trial of any of the following preferred short-acting opioids:** *(If yes, check all that apply and complete Section D above with medication information)* □ Acetaminophen-codeine □ Butalbital-acetaminophen-caffeine-codeine (Generic Fioricet) □ Butalbital-aspirin-caffeine-codeine (generic Fiorinal) □ Hydrocodone-acetaminophen (generic Norco) □ Hydrocodone-ibuprofen □ Hydromorphone (generic Dilaudid) □ Meperidine □ Morphine sulfate □ Oxycodone (generic Roxicodone) □ Oxycodone-acetaminophen (generic Percocet) □ Oxycodone-ibuprofen □ Tramadol (generic Ultram)
□ Yes □ No	**<u>Requests for long-acting opioids:</u>** **Does the patient have a history of failure, contraindication or intolerance to a trial of any of the following:** *(If yes, check all that apply and complete Section D above with medication information)* □ Butrans (buprenorphine) □ Fentanyl transdermal patches (12, 25, 50, 75, and 100mcg) □ Morphine sulfate controlled release tablets (specifically generic MS Contin) □ Tramadol extended release tablets (non-biphasic release tablets) □ Tramadol immediate release □ Xtampza ER (oxycodone extended-release)

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CANCER/HOSPICE/END-OF-LIFE RELATED PAIN	
□ **Yes** □ **No**	**Is the patient being treated for cancer related pain?** *If yes, list cancer diagnosis:* *Date of diagnosis:* ***(REQUIRED)***
□ **Yes** □ **No**	**Is the patient established on pain therapy with the requested medication for cancer, hospice care, or end-of-life care pain, and the medication is not a new regimen for treatment of cancer, hospice care, or end-of-life care pain?** *If yes, document date regimen was started:*
NON-CANCER/NON-HOSPICE/NON-END-OF-LIFE RELATED PAIN	
□ **Yes** □ **No**	**Is the patient being treated for one of the following?** *(If yes, check which applies)* □ Neuropathic pain (e.g. neuralgias, neuropathies, fibromyalgia) □ Non-neuropathic pain
□ **Yes** □ **No**	**Has the patient exhibited an inadequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose, unless it is contraindicated?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Has the patient exhibited an inadequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose, unless it is contraindicated?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Prior to the start of therapy with the long-acting opioid, has the patient failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is the request for postoperative pain and the patient is already receiving chronic opioid therapy prior to surgery or the postoperative pain is expected to be moderate to severe and persist for an extended period of time?**
GREATER THAN TWO SHORT ACTING OPIOIDS	
□ **Yes** □ **No**	**Is the requested medication being used to adjust the dose of the drug?**
□ **Yes** □ **No**	**Will the requested medication be used in place of the previously prescribed drug, and not in addition to it?**
□ **Yes** □ **No**	**Will the requested medication dosage form be used in place of the previously prescribed medication dosage form, and not in addition to it?**
□ **Yes** □ **No**	**Does the physician attest they are aware of the multiple short acting opioids prescribed to the patient and feels treatment with all medications is medically necessary?** *If yes, list rationale:*
USE OF MEDICATION ASSISTED TREATMENT (MAT) AND OTHER OPIOIDS	
□ **Yes** □ **No**	**Does the provider attest to notify the prescriber of the MAT (medication assisted treatment) therapy and the prescriber of the MAT therapy approves the concurrent opioid therapy?**
□ **Yes** □ **No**	**Is the patient having (or has had) a surgical procedure?**

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QUANTITY LIMIT REQUESTS	
□ Yes □ No	**Can the requested dose be achieved by moving to a higher strength of the product?**
□ Yes □ No	**Is the requested dose within the FDA maximum dose per day, where an FDA maximum dose per day exists *(see table below)*?**

Active Ingredient	FDA Label Max Daily Doses	90 MME (mg/day) (non treatment naïve)
Morphine	None	90mg
Morphine and naltrexone	None	90mg
Hydromorphone	None	22.5mg
Hydrocodone	None	90mg
Fentanyl transdermal, mcg/hr	None	37.5mcg/hr
Methadone	None	Conversion factor is variable based upon dose
Tapentadol	500 mg ER Products	225mg
Oxymorphone	None	30mg
Oxycodone	Xtampza Only = 288mg	60mg
Tramadol	300mg ER products	900mg

CUMULATIVE 90 MORPHINE MILLIGRAM EQUIVALENT (MME)	
□ 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)*
□ Yes □ No	**Does the provider attest that the patient has been prescribed naloxone?**

CONTINUATION OF THERAPY	
□ Yes □ No	**Has the patient demonstrated meaningful improvement in pain and function?** *If yes, list documented improvement in function or pain score improvement:*
□ Yes □ No	**Is there rationale for not tapering and discontinuing opioid?** *If yes, document rationale:*
□ Yes □ No	**Does the provider attest that the patient has been prescribed naloxone?**

Provider Signature: _____ **Date:** _____