Print Reset

United Healthcare Community Plan

FLORIDA MEDICAID PRIOR AUTHORIZATION

OPIOID AGENTS

LENGTH OF APPROVAL: UP TO 3 MONTHS

Note: Form must be completed in full.

An incomplete form may be returned.

Recipient's Full Name:

Recipient's Medicaid ID#:

Date of Birth (MM/DD/YYYY): / /

Prescriber's Full Name:

Prescriber's NPI:

Prescriber Phone Number: - -

Prescriber Fax Number: - -

☐ **Short-Acting Opioid** ☐ **Long-Acting Opioid** ☐ **Both**

Drug Name: _____

Drug Strength: _____

Dose: _____

Directions: _____

Diagnosis: _____

Prescriber's Specialty (or consultation with a specialist): _____

1. There was a trial and failure of the following medication(s) prior to prescribing short-acting opioids (check all that apply):
   ☐ Baclofen ☐ NSAIDs (oral) ☐ Tricyclic antidepressant (e.g., amitriptyline)
   ☐ Lyrica ☐ Duloxetine ☐ Other: _____
   - Any requests for post-operative, short-acting opioids cannot exceed a 7-day supply without medical justification.
   - Long-acting opioids are indicated for patients with chronic, moderate to severe pain who require around-the-clock opioid analgesics. Supporting documentation of a minimum two-month trial of short-acting opioid use is required.
2. If the request is for a non-preferred agent, trial and failure of preferred agents is required. Medical records documenting trials are also required. **List the names of the medications, strength, frequency, length of trials, and rationale for discontinuation**.
3. What is the daily morphine milligram equivalent (MME) of the prescribed medication(s)? _____
   - If patient is treatment-naïve (MME exceeding 90), PA will not be approved.

(Form continued on next page.)

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4. Did the prescriber review the **Prescribed Drug Monitoring Program** prior to prescribing this opioid medication as required by Florida statute?

   ☐ Yes ☐ No

   a. If NO, explain why: _____

   - Submission of a signed patient-prescriber pain management, opioid treatment agreement is required for chronic pain patients

5. When is the next office visit scheduled for the patient with chronic pain? Date: _____

6. Has the prescriber ordered and reviewed a urine drug screen (UDS) for new chronic pain patients prior to initiation of opioid therapy? (Submission of a UDS within the past 90 days is required.)

   ☐ Yes ☐ No

   a. If NO, explain why: _____

Continuation of Ongoing Therapy

1. Has the prescriber ordered and reviewed a UDS for patients with chronic pain to ensure compliance of opioid therapy? (Submission of a UDS within the past 90 days is required.)

   ☐ Yes ☐ No

2. When is the next office visit scheduled for the patient with chronic pain? Date: _____

3. If requesting an increase in dose or frequency, calculate the new daily morphine milligram equivalent (MME) of the prescribed medication(s) and provide rationale for why this dose is medically necessary.

****Clinicians should consider offering naloxone to patients with an increased risk of opioid overdose.****

I certify that the benefits of opioid treatment for this patient outweigh the risk of treatment.

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

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes) and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center:
1-855-258-1593

02.15.2024