

Opiate Dependence Treatments - Nebraska 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:
NPI #:	Phone:	Fax: 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

Member First name:	Member Last name:	Member DOB:
---------------------------	--------------------------	--------------------

Clinical and Drug Specific Information

- What is the patient's diagnosis? (check which applies)

- Opioid Use Disorder
- Pain management
- Other. List diagnosis: _____

- Does the prescriber have an 'X' DEA license number? Yes No

- Is the patient on concomitant opioids? Yes No

- Does the patient have a history of a trial and failure with the preferred medication? Yes No
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- Is there patient-specific documentation of why the preferred medication is not appropriate for the patient?
 Yes No **If yes, list reason:** _____

Provider Signature: _____ **Date:** _____

Confidentiality Notice: This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.