UnitedHealthcare Community Plan

Opioid Products - 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:
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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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

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

- **The information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.**
- **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**
- **Pain is chronic**
- **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)**
- **Pain management is required around the clock with a long-acting opioid**

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 □ End-of-life care (other than hospice) □ Hospice care □ Palliative care □ Acute pain
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to a trial of at least THREE preferred short acting opioids within the last 12 months?** *(If yes, please complete Section D above)*
□ Yes □ No	**Has the patient tried and failed non-opioid pain medication?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have a history of failure on, or intolerance to, a trial of any of the following?** *(If yes, check which applies and complete Section D above)* □ Morphine sulfate controlled release tablets (specifically generic MS Contin) □ Preferred fentanyl transdermal (25mcg, 50mcg, 75mcg, 100mcg) □ Embeda □ Oxycontin □ Butrans

CANCER, HOSPICE, or END OF LIFE PAIN

□ Yes □ No	**Is the patient established on pain therapy with the requested medication for cancer-related pain, hospice related pain, or end-of-life care related pain, and the medication is not a new regimen for treatment of cancer-related pain, hospice, or end-of-life care pain?** *If yes, list date the regimen was started:*

NON-CANCER, NON-HOSPICE, and NON-END OF LIFE

□ 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?**

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TRAMADOL/APAP	
□ Yes □ No	**Is there a clinical reason why the patient cannot use the individual ingredients (Note: Individual ingredients are preferred: tramadol IR + acetaminophen)?** *If yes, list clinical reason:*
NEW TO THERAPY FOR SHORT ACTING OPIATES ONLY	
□ Yes □ No	**Does the patient have any of the following?** *(If yes, check which applies)* □ Sickle cell anemia □ Traumatic injury □ Post-surgical procedures, excluding dental procedures □ Prescriber attests that the patient has received an opioid within the past 90 days
□ Yes □ No	**Does the prescriber attests to both of the following?** *(If yes, check which applies)* □ 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 sickle cell anemia or traumatic injury or post-surgical procedure, prescriber attests that based on disease state or injury or surgical procedure performed the member requires greater than a 7 day supply of short-acting opioid to adequately control pain.
□ Yes □ No	**Has the provider documented ALL of the following?** *(If yes, check which applies)* □ The diagnosis is associated with the need for pain management with opioids. □ 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. □ The prescriber has acknowledged that they have completed an addiction risk and risk of overdose assessment. □ Prescriber attests the member requires more than 50 MED per day to adequately control pain.
CUMULATIVE 250 MED AND/OR 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	**Has the patient tried doses of less than 250 MED that did not adequately control pain?** *(If yes, complete Section D above)*
□ Yes □ No	**Is there rationale for not tapering and discontinuing opioid?** *If yes, list rationale:*
□ Yes □ No	**Is there a pain management contract?**

Provider Signature: _____ Date: _____