UnitedHealthcare Community Plan

Opioid Products
Prior Authorization Request Form—Maryland

UnitedHealthcare Community Plan is aligning with Centers for Disease Control and Prevention guidelines for prescribing opioids. **Please complete this entire form and fax it to: 866-940-7328. Lack of form completion will delay the review process. If you have questions, please call 800-310-6826. Thank you.**

Section A — Patient Information		
Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	ZIP code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:
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 — Physician Information			
First Name:	Last Name:		
Address:	City:	State:	ZIP:
Phone:	Fax:	NPI #:	
Specialty:	Office Contact Name / Fax Attention to:		

Section C — Clinical Information	
Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (please provide specific details):	**ICD-10 code:**

Cumulative Morphine Equivalent Dose (MED) of Total Opioid Regimen:		
Opioid Agent	**Long-Acting Opioid Preferred Products**	**90 MED Equivalent**
Buprenorphine Buccal	No preferred option	3000 micrograms (mcg)
Buprenorphine Transdermal	No preferred option	50 mcg/hour
Codeine	No preferred option	600mg
Fentanyl Transdermal	Fentanyl Patch 25, 50, 75, 100	37.5 mcg/hour
Hydrocodone	Zohydro ER	90 mg
Hydromorphone	No preferred option	22.5 mg
Meperidine	No preferred option	900mg
Methadone	No preferred option	30 mg
Morphine	Generic Morphine ER	90 mg
Oxycodone	No preferred option	60 mg
Oxymorphone	Generic Oxymorphone ER	30 mg
Pentazocine	No preferred option	243mg
Tapentadol	No preferred option	225 mg
Tramadol	No preferred option	900mg

We are required to have your signature and the date you signed the form.

□ I certify that the benefits of opioid treatment for this patient outweigh the risks of treatment and that the information provided is true and accurate to the best of my knowledge. I understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.

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.

UnitedHealthcare
Community Plan

Opioid Products
Prior Authorization Request Form—Maryland

Patients with Cancer, Sickle Cell, or Palliative Care or are in a Hospice or LTC facility do not need to complete the rest of the form. Unless requesting a non-preferred, then fill out the below non-preferred questions only.

Non-Preferred Product Requests for ALL DIAGNOSES

□ **FOR NON-PREFERRED LONG-ACTING OPIOIDS ONLY:** Does the patient have a history of failure, contraindication or intolerance to a trial of any of the following: Check all that apply.
- □ fentanyl transdermal
- □ morphine sulfate controlled release tablets (specifically generic MS Contin)
- □ Oxymorphone extended release (ER) non-crush resistant (generic)
- □ Zohydro ER

Document drugs, dose, duration and date of trials: _____

□ **FOR NON-PREFERRED SHORT-ACTING OPIOIDS ONLY:** Does the patient have a history of failure, contraindication or intolerance to a trial of three preferred short-acting opioid agents?

Document drugs, dose, duration and date of trials: _____

Initial Requests for LONG-ACTING OPIOIDS ONLY

Is the patient being treated for moderate to severe chronic pain that is non-neuropathic (examples of **neuropathic** pain include neuralgias, neuropathies, fibromyalgia)? □ **Yes** □ **No** **(If non-neuropathic, skip to section All Non-Cancer Pain Requests — *Initial Requests for LONG-ACTING OPIOIDS ONLY.)***

Neuropathic Pain — Please answer the following questions:

Is the patient being treated for moderate to severe neuropathic pain or fibromyalgia? □ **Yes** □ **No**

Please indicate if any of the following apply:

□ Has the patient exhibited an adequate response to eight weeks of treatment with gabapentin titrated to a therapeutic dose? □ **Yes** □ **No**

If "Yes", document duration and date of trial: _____

□ Has the patient not exhibited an adequate response to at least six weeks of treatment with a tricyclic antidepressant titrated to a therapeutic dose? □ **Yes** □ **No**

If "Yes", document duration and date of trial: _____

Initial Requests for LONG-ACTING OPIOIDS ONLY

Please indicate if any of the following apply:
- □ For use as an as-needed analgesic
- □ For pain that is mild or not expected to persist for an extended period of time
- □ For acute pain
- □ For post-operative pain

Is the patient already receiving chronic opioid therapy prior to surgery? □ **Yes** □ **No**

Is the post-operative pain expected to be moderate to severe and persist for an extended period of time? □ **Yes** □ **No**

Has the patient failed an adequate (minimum of two- week) trial of a short-acting opioid? □ **Yes** □ **No**

If yes, document drug(s), dose, duration and date of trial: _____

Initial AND Reauthorization Requests for ALL OPIOID AUTHORIZATIONS

Please provide defined treatment goals, including estimated duration of treatment:
- Treatment goals: _____
- Estimated duration of treatment: _____

Does the treatment plan include use of a non-opioid analgesic and/or non-pharmacologic intervention? □ **Yes** □ **No**
- *List other treatment interventions:* _____

Has the patient been screened for substance abuse/opioid dependence? □ **Yes** □ **No**
- Screening is used in patients with medical comorbidities or, if used concurrently, with a benzodiazepine or other drugs that could potentially cause drug-drug interactions:

Has an assessment of increased risk for respiratory depression has been completed by the prescriber? □ **Yes** □ **No**

□ Has an assessment of increased risk for respiratory depression has been completed by the prescriber? □ **Yes** □ **No**

□ Was the Prescription Drug Monitoring Program, which is part of the Chesapeake Regional Information System for Patients in Maryland, checked for other controlled substances before prescribing? □ **Yes** □ **No**

□ Was Naloxone offered to the patient or the patient's house hold? □ **Yes** □ **No**

□ Will the patient be required to complete random urine drug screens as part of their on-going therapy on opioids? □ **Yes** □ **No**

□ Has a patient-prescriber pain management contract been signed and attached in the medical record? □ **Yes** □ **No**

□ Doses of opioid product(s) exceeding a cumulative 90 MED? (see table on page 1)

Did you consult a pain specialist, defined as a prescriber with a pain management specialty designated by the American Board of Anesthesiology, or one of the following specialties: hematology, oncology, anesthesiology, neurology, or physiatry? □ **Yes** □ **No**

Document prescriber specialty and total daily dose: _____

Reauthorization Requests for ALL OPIOID AUTHORIZATIONS

Has the patient demonstrated meaningful improvement in pain and function using a validated instrument (e.g. Brief Pain Inventory)? □ **Yes** □ **No**

- *Score:* _____
- *Instrument used:* _____

Identify rationale for not tapering and discontinuing opioid.

- *Rationale:* _____

Explanation of why preferred medications would not meet the patients' needs **Please refer to www.uhccommunityplan.com for a list of preferred alternatives**

Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: _____ **Date:** _____