UnitedHealthcare Community Plan

Long-Acting Opiates

Prior Authorization Form – Arizona

UnitedHealthcare Community Plan is aligning with Centers for Disease Control and Prevention guidelines for prescribing long-acting opioids. Please complete this entire form and fax it to: **866-940-7328**. 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:	Date of Birth:	Allergies:	
Primary Insurance:	Policy #:	Group #:	
Is the requested medication **new** ☐ or **a continuation of therapy** ☐? If so, what is the start date? _____			
Is this patient currently hospitalized? ☐ **Yes** ☐ **No**			

Section B – Physician Information			
First Name:	Last Name:		
Address:	City:	State:	Zip code:
Phone:	Fax:	NPI #:	
Specialty:	Office Contact Name:		

Section C – Clinical Information	
Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please provide specific details.):	ICD-10 code:
Long-Acting Opioid	**Maximum Daily 90 Morphine Equivalent Dose (MED)**
Buprenorphine Buccal (e.g. BelbucaTM)	3000 micrograms (mcg)
Buprenorphine Transdermal (e.g. Butrans®)	50 mcg/hour
Fentanyl Transdermal (e.g. Duragesic®)	37.5 mcg/hour
Hydrocodone (e.g. Hysingla® Extended Release)	90 mg
Hydromorphone (e.g. Exalgo®)	22.5 mg
Methadone	30 mg
Morphine (e.g. generic MS Contin)	90 mg
Oxycodone (e.g. Oxycontin)	60 mg
Oxymorphone (e.g. Opana® ER)	30 mg
Tapentadol (e.g. Nucynta® ER)	225 mg

☐ 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. Prior authorization is not required. 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 our Preferred Drug List for preferred products.

Does the patient have a history of failure, contraindication or intolerance to a trial of any of the following:

- ☐ Butrans transdermal
- ☐ fentanyl transdermal
- ☐ Hysingla ER
- ☐ morphine sulfate controlled release tablets (specifically generic MS Contin or Embeda)
- ☐ Oxycontin

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

Cancer Treatment – *Initial request and continuation of therapy*

Is patient receiving opioid due to cancer treatment? ☐ **Yes** ☐ **No** If yes, please complete the following:

Cancer type:_____ Date of diagnosis:_____

Non-Cancer Treatment – *Initial Requests*

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)**

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 drug, date, and duration of trial:* _____

All Non-Cancer Pain Requests – *Initial Requests*

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: _____

All Non-Cancer Pain Requests – *Initial AND Reauthorization Requests*

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**

Dose of long-acting opioid exceeds maximum 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: _____

Non-Cancer Treatment – *Reauthorization Requests*

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 long-acting opioid.

- *Rationale:* _____

Explain why the preferred medication(s) do not meet your patient's needs:

List other medications tried:

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation