UnitedHealthcare Community Plan

Opioid Products – Maryland
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 contains 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:	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 - 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

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information about this case, if any:

Clinical and Drug Specific Information

□ ***I certify the information provided is true and accurate to the best of our knowledge and we 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.

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Member First name:	Member Last name:	Member DOB:

All Requests for Cancer Related Pain/Sickle Cell/Hospice Related Pain
(Complete this section only for Cancer Related Pain/Sickle Cell/Hospice)

1. □ Yes □ No Does the patient have any of the following diagnoses? (check which applies)
Date of Diagnosis: _____
□ Cancer Related Pain □ Sickle Cell Pain □ Hospice Related Pain

2. □ Yes □ No Is the patient currently in hospice care?

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

4. □ Yes □ No Does the patient have a history of failure, contraindication or intolerance to a trial of any of the following: (check all that apply, and complete Section D above with medication information)

☐ Morphine sulfate controlled release tablets (specifically generic MS Contin)

☐ Fentanyl transdermal (12, 25, 50, 75, and 100mcg) ☐ Oxymorphone ER non-crush resistant (generic)

□ Zohydro ER

Attestation Required of all Prescribers for Non-Exempt Patients

A. <u>For Outpatient Prescribers providing ongoing care: *EACH Question Must Be Answered*</u>

□ Yes □ No Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
□ Yes □ No Patient has/will have random Urine Drug Screens (UDS).
□ Yes □ No Naloxone prescription was provided or offered to patient/patient's household.
□ Yes □ No Patient-Prescriber Pain Management/Opioid Treatment Agreement signed and in medical record.

B. <u>For Inpatient Hospital (Hospital), Ambulatory Surgery Center (ASC), and Emergency Room (ER) Prescribers: *EACH Question Must Be Answered*</u>

□ Yes □ No Prescriber has reviewed Controlled Substance Prescriptions in PDMP (CRISP).
□ Yes □ No Naloxone prescription provided or offered to patient/patient's household.
□ Yes □ No I have discussed the risks/benefits associated with opioid use with patient/patient's household.
□ Yes □ No The patient is exempt from need for a Patient-Prescriber Pain Management/Opioid Treatment Agreement and random UDS, because he/she is being discharged from the Hospital/ASC/ER and opioid treatment prescribed by the discharging provider will be for less than 30 days or the need for further opioid use will be re-evaluated by an Outpatient provider within 30 days.

I certify that the benefits of opioid treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber Signature: _____ Date: _____
<u>Important:</u> Incomplete attestations will not be able to be processed by Medicaid FFS or MCO and will delay requests

All Requests for Non-Cancer Pain/Non-Sickle Cell/Non-Hospice Pain

1. □ Yes □ No Does the patient have any of the following diagnoses? (check which applies)
□ Cancer Related Pain □ Sickle Cell Pain □ Hospice Related Pain
□ Other Pain: _____
If yes, date of diagnosis: _____

2. □ Yes □ No Is the patient being treated for one of the following? (if yes, check which applies)
□ Moderate to severe chronic pain that is non-neuropathic
□ Moderate to severe neuropathic pain or fibromyalgia

3. □ 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?

4. □ Yes □ No Have treatment goals been defined, including estimated duration of treatment? (If yes, explain)
List treatment goals: _____
List estimated duration of treatment: _____

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

_____

6. □ Yes □ No Has the patient demonstrated meaningful improvement in pain and function using a validated instrument (e.g. Brief Pain Inventory)?
If yes, document score and instrument used: _____

7. □ Yes □ No Does the request meet any of the following: (If yes, check which applies)
- □ Medication is being used as an as-needed PRN analgesic
- □ Medication is being used for pain that is mild or not expected to persist for an extended period of time
- □ Medication is being used for acute pain
- □ Medication is being used for postoperative pain, 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

If patient meets any please provide details: _____

8. □ Yes □ No Has the patient been screened for substance abuse (including opioid dependence)?

9. □ Yes □ No Is the requested medication being used in a patient with medical comorbidities?
If yes, list medical comorbidities: _____

10. □ Yes □ No Is the requested medication being used with a benzodiazepine or other drug that could potentially cause drug-drug interactions?
If yes, list interacting medications: _____

11. □ Yes □ No Has an assessment of increased risk for respiratory depression been completed?

12. □ Yes □ No <u>For Long Acting Opioids:</u> Does the patient have a history of failure, contraindication or intolerance to a trial of any of the following: (check all that apply, and complete Section D above with medication information)

☐ Morphine sulfate controlled release tablets (specifically generic MS Contin)

☐ Fentanyl transdermal (12, 25, 50, 75, and 100mcg) ☐ Oxymorphone ER non-crush resistant (generic)

☐ Zohydro ER

13. □ Yes □ No Has the patient exhibited an inadequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose, unless it is contraindicated?
(if yes, complete section D above with medication information)

14. □ Yes □ No Has the patient exhibited an inadequate response to 6 weeks of treatment with a tricyclic antidepressant titrated to a therapeutic dose, unless it is contraindicated?
(if yes, complete section D above with medication information)

15. □ 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 with medication information)

16. □ Yes □ No <u>For Short Acting Opiods:</u> Has the patient had a failure, contraindication or intolerance to three preferred short acting opioids?
(If yes, complete Section D above with medication information. (*refer to www.uhccommunityplan.com for preferred alternatives*)

<u>FOR CONTINUING THERAPY REQUESTS ONLY</u> (not for initial opioid requests)

1. □ Yes □ No Has the patient demonstrated meaningful improvement in pain and function using a validated instrument (e.g. Brief Pain Inventory)?
If yes, document score and instrument used: _____

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2. □ Yes □ No Has the prescriber indicated rationale for not tapering and discontinuing opioid?
If yes, list rationale: _____

Requests for Quality Limit/Exceeding the 90MED Cumulative Threshold

Please note the plan's quantity limits:

Active Ingredient	FDA Label Max Daily Doses	Max MED (mg/day)
Morphine	None	90mg
Buprenorphine	1800mcg	3000mcg
Buprenorphine transdermal patch	20mcg/hr	50mcg/hr
Morphine and Naltrexone	None	90mg
Hydromorphone	None	22.5mg
Fentanyl transdermal, mcg/hr	None	37.5 mcg/hr
Hydrocodone	None	90mg
Methadone	None	Conversion factor variable upon dose
Tapentadol	500mg ER products 600mg IR products	225mg
Oxymorphone	None	30mg
Oxycodone	Xtampza Only =288mg	60mg
Codeine	360mg	600mg
Pentazocine	None	243mg
Tramadol	400mg IR products 300mg ER products	900mg
Meperidine	600mg	900mg
Butorphanol	12.8mg	

1. □ Yes □ No Can the requested dose be achieved by moving to a higher strength of the product?
If yes, list reasoning for not switching: _____

2. □ Yes □ No Is there a reason why a greater quantity of medication is required to treat the patient's condition?
If yes, list reason: _____

3. □ Yes □ No Does the request exceed the FDA approved limit or maximum Morphine Equivalents per day (MED)?
If yes, list reason: _____

4. □ Yes □ No Is the requested medication being prescribed by or in consultation with a pain specialist (defined as a prescriber with a pain management specialty designated by the American Board of Anesthesiology; or one of the following specialists: hematology, oncology, anesthesiology, neurology, or physiatry)?
If yes, list provider specialty and total daily dose: _____

For Cough and Cold Narcotic Products ONLY exceeding the MED threshold:

1. □ Yes □ No I attest that I am aware of the patient's current opioid therapy and MED dose and feel the treatment with the requested product is medically necessary.

Physician Signature: _____ **Date:** _____