UnitedHealthcare Community Plan

Cough and Cold (Opiate Products) – Virginia
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.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

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: _____
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____
_____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

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Patient First name:	Patient Last name:	Patient DOB:

Clinical and Drug Specific Information	
AGE LESS THAN 18 YEARS	
□ Yes □ No	**Does the prescriber attest they are aware of Food and Drug Administration (FDA) labeled contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary?** *If yes, document rationale for use:*
□ Yes □ No	**Does the patient have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index greater than 30)?**
□ Yes □ No	**Has the patient tried and failed at least one non-opioid containing cough and cold remedy?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
NON-PREFERRED COUGH AND COLD PRODUCTS	
□ Yes □ No	**Does the patient have a history of contraindication, drug-drug interaction with, or toxic side effects that cause immediate or long-term damage from at least TWO preferred products?** **NOTE: Toxic side effects do NOT include GI (gastrointestinal) intolerance** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
EXCEEDING THE 90 MORPHINE MILLIGRAM EQUIVALENT (MME) CUMULATIVE THRESHOLD	
□ Yes □ No	**Does the prescriber attest they are aware of patient's current opioid therapy and MME dose and feels the treatment with the requested product is medically necessary?**

Provider Signature: _____ **Date:** _____