UnitedHealthcare Community Plan

Transmucosal Fentanyl Products - Washington
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 at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ No	**Does the patient have a confirmed diagnosis of cancer?**
□ Yes □ No	**Is the patient currently receiving around-the-clock long-acting opioids for persistent cancer pain?** *If yes, list medication(s):*
□ Yes □ No	**Is the patient tolerant on at least 60 MME per day of chronic, long-acting opioids as demonstrated by any of the following?** *(If yes, check which applies)* □ Doses less than 120 MME approved through cancer-pain expedited authorization □ Doses between 120 MME and 200 MME require a signed and approved Opioid High Dose form □ Doses above 200 MME have an approved prior authorization on file
□ Yes □ No	**Is the patient using transmucosal fentanyl for the treatment of breakthrough cancer pain?**
□ Yes □ No	**Does the patient have a history of failure to TWO oral immediate-release opioid products (e.g., morphine, hydromorphone, oxycodone)?** *(If yes, complete Section D above)*
□ Yes □ No	**Does any of the following apply to the patient?** *(If yes, check which applies)* □ Currently non-tolerant to opioids □ Currently not on a long-acting opioid for the treatment of cancer pain □ Management of acute or postoperative pain not related to cancer treatment, including headache/migraine, dental pain, or in an emergency room
□ Yes □ No	**Is the requested medication prescribed by or in consultation with a specialist in oncology or pain management related to oncology?**
□ Yes □ No	**Is the patient enrolled in or eligible for hospice care?**
CONTINUATION OF THERAPY	
□ Yes □ No	**Is the cancer-related pain for the patient controlled and titrated appropriately as to minimize the use of transmucosal fentanyl products?**

Provider Signature: _____ **Date:** _____