DEPARTMENT OF HUMAN SERVICES

DHS-7072-ENG 8-18

MINNESOTA HEALTH CARE PROGRAMS (MHCP)

# High Dose Opioid Drug Prior Authorization

This form is for requesting prior authorization for opiate containing prescription medication over 90 morphine equivalents per day (90 MED). Beginning on August 20, 2018, all opiate prescriptions for MHCP recipients are limited to 90 morphine equivalents per day. All previously approved prior authorizations above this limit will reject and a new request must be submitted. This is in addition to drug specific clinical criteria. Find drug specific criteria on the MHCP Provider website.

Obtain authorization by faxing the required information to the fax number below. Include a completed prior authorization form, copy of the pain management plan or chart notes, attestation of a Prescription Drug Monitoring Program (PDMP) evaluation, and rationale for need for quantities over 90 morphine equivalents per day with the request.

**UnitedHealthcare Community Plan**
**Phone:** 1-800-310-6826
**Fax:** 1-866-940-7328

**You must have this information available before calling or faxing.**
**Bolded fields are required before PA can be reviewed. Incomplete forms will be returned.**

## Requestor Information

| REQUESTOR NAME | PHONE NUMBER (include area code) | AFFILIATION (check one) ☐ Pharmacy ☐ Prescriber |
|---|---|---|
| | | |

## Requestor Checklist – Required Information for Complete Request

☐ Documentation of medical necessity of drug and dose

☐ Opioid risk assessment

☐ PDMP evaluation

| PDMP ATTESTATION SIGNATURE | DATE REVIEWED |
|---|---|
| | |

☐ Pain management plan signed by patient

## Documentation Examples

**Examples of documentation of medical necessity of drug and dose**
(Treatment plans should include assessment, evaluation, goals and plan for periodic review)
- Notes in chart (subjective and objective) documenting clinical need for high doses
- Treatment plan (pain management plan)
- Tapering schedule if applicable
- Pain contract

**Examples of opioid risk assessment**
- Assess for evidence of overuse
- Multiple prescribers and multiple clinics
- History of abuse, diversion or dependence
- Specific drug requests

**Examples of comprehensive pain management plan**
- Treatment plan (pain management plan)
- Tapering schedule, if applicable
- Pain contract

**Complete both pages**

# Required Pharmacy and Provider Information

| | | | | |
|---|---|---|---|---|
| **PHARMACY NAME** | **PHARMACY NPI** | **PHONE NUMBER** (include area code) | **FAX NUMBER** (include area code) | |
| **PRESCRIBER NAME** | **PRESCRIBER NPI** | **PHONE NUMBER** (include area code) | **FAX NUMBER** (include area code) | |
| **DRUG NAME / STRENGTH** | | **NDC** | **QUANTITY** | **REFILLS** |
| **DIRECTIONS** | | | AUTH START DATE (m/d/yyyy) | |
| **RECIPIENT NAME** | | **RECIPIENT MA ID NUMBER** | **RECIPIENT DATE OF BIRTH** (m/d/yyyy) | |
| **DIAGNOSIS** | | | | |
| **DOCUMENTATION OF STATUS CHANGE OR ADVERSE REACTION CAUSED BY TRIALS OF OTHER MEDICATIONS** (CHART DOCUMENTATION MAY BE ATTACHED) | | | | |
| OTHER PERTINENT CLINICAL INFORMATION | | | | |