UnitedHealthcare Community Plan

# Opioid Products - Hawaii
## 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 |
|---|---|---|---|---|
| | | | | |
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**Section E – Additional information about this case, if any:**
**Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives**

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|---|---|---|

## Clinical and Drug Specific Information

| | |
|---|---|
| □ Yes □ No | **Does the prescriber attest to ALL of the following: (REQUIRED)** |

- **The information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.**
- **Patient has been screened for substance abuse/opioid dependence**
- **Pain is moderate to severe and expected to persist for an extended period of time [chronic]** *(Long-acting opioids only)*

***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 MME/day, or concurrent use with benzodiazepines. Please refer to Preferred Drug Plan for preferred products***

### ALL REQUESTS

| | |
|---|---|
| □ Yes □ No | **Does the patient meet any of the following conditions or care instances?** *(If yes, check all that apply)*<br>□ Cancer diagnosis<br>□ End-of-life care<br>□ Hospice care<br>□ Non-cancer pain<br>□ Palliative care<br>□ Post-surgery<br>□ Sickle cell anemia |
| □ Yes □ No | **Have treatment goals been defined and include estimated duration of treatment?**<br>*If yes, document treatment goals:* |
| □ Yes □ No | **Has the patient been screened for underlying depression and/or anxiety?** |
| □ Yes □ No<br>□ Not applicable | **If applicable, have any underlying conditions been or will be addressed?** |
| □ Yes □ No | **Requests for short-acting opioids:**<br>**If the request is for a non-preferred medication, has the patient had a failure, contraindication or intolerance to three preferred short acting opioids?** *(If yes, complete Section D above)* |
| □ Yes □ No | **Requests for long-acting opioids:**<br>**Does the patient have a history of failure, contraindication or intolerance to a trial of any of the following?** *(If yes, check all that apply and complete Section D above)*<br>□ Fentanyl transdermal (12, 25, 50, 75, and 100mcg)<br>□ Hydrocodone extended-release capsules (generic Zohydro ER)<br>□ Morphine sulfate controlled release tablets (generic MS Contin)<br>□ Oxymorphone ER non-crush resistant (generic) |
| □ Yes □ No | **Does the patient have a history of failure, contraindication or intolerance to a trial of tramadol immediate release?** *(If yes, complete Section D above)* |
| □ Yes □ No | **Requests for Tramadol 100mg tablets:**<br>**Is there rationale for needing to use the 100 mg tramadol tablet instead of two 50 mg tramadol tablets?**<br>*If yes, document rationale:* |
| □ Yes □ No | **Requests for Qdolo:**<br>**Does the patient meet any of the following?** *(If yes, check all that apply)*<br>□ Patient has a history of failure, contraindication or intolerance to a trial of tramadol 50 mg tablets *(If yes, complete Section D above)*<br>□ Patient is unable to swallow a solid dosage form<br>□ Patient utilizes a feeding tube for medication administration |

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| | |
|---|---|
| **NEW TO THERAPY FOR SHORT ACTING OPIATES ONLY** | |
| □ **Yes** □ **No** | **Does the patient have any of the following?** *(If yes, check which applies)*<br>□ Traumatic injury<br>□ Post-surgical procedures, excluding dental procedures<br>□ Prescriber attests that the patient has received an opioid within the past 60 days |
| □ **Yes** □ **No** | **Does the prescriber attest to both of the following?** *(If yes, check which applies)*<br>□ The information provided is true and accurate to the best of their knowledge and they understand that United HealthCare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.<br>□ If requested for traumatic injury or post-surgical procedure, prescriber attests that based on injury or surgical procedure performed the member requires greater than a 7 day supply of short-acting opioid to adequately control pain. |
| □ **Yes** □ **No** | **Has the provider documented ALL of the following?** *(If yes, check which applies)*<br>□ The diagnosis is associated with the need for pain management with opioid.<br>□ If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression.<br>□ The prescriber has acknowledged that they have completed an addiction risk and risk of overdose assessment.<br>□ Prescriber attests the member requires more than 50 MME per day to adequately control pain. |
| **CANCER / HOSPICE / END-OF LIFE RELATED PAIN** | |
| □ **Yes** □ **No** | **Is the patient being treated for cancer related pain?**<br>*If yes, list cancer diagnosis:* |
| □ **Yes** □ **No** | **Is the patient established on pain therapy with the requested medication for cancer-related pain, hospice related pain, or end-of-life care related pain, and the medication is not a new regimen for treatment of cancer-related pain, hospice, or end-of-life care pain?**<br>*If yes, document date regimen was started:* |
| **NON-CANCER / NON-HOSPICE / NON-END-OF-LIFE RELATED PAIN** | |
| □ **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)* |
| □ **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?** |
| □ **Yes** □ **No** | **Is the patient being treated for one of the following?** *(If yes, check which applies)*<br>□ Neuropathic pain (e.g. neuralgias, neuropathies, fibromyalgia)<br>□ Non-neuropathic pain |
| □ **Yes** □ **No** | **<u>For neuropathic pain requests</u>, unless it is contraindicated, has the patient exhibited an inadequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose?** *(If yes, complete Section D above)*<br>□ Check box if Gabapentin is contraindicated |
| □ **Yes** □ **No** | **<u>For neuropathic pain requests</u>, unless it is contraindicated, has the patient exhibited an inadequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose?**<br>*(If yes, complete Section D above)*<br>□ Check box if tricyclic antidepressant is contraindicated |

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**QUANTITY LIMIT & EXCEEDING 90 MME CUMULATIVE THRESHOLD**

**Please note the plan's quantity limits:**

| Active Ingredient | FDA Label Max Daily Doses | Max MME (mg/day) (non treatment naïve) |
|---|---|---|
| Morphine | None | 90mg |
| 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 is variable based upon dose |
| Tapentadol | 600mg IR products<br>500mg ER products | 225mg |
| Oxymorphone | None | 30mg |
| Oxycodone | Xtampza Only =288mg | 60mg |
| Codeine | 360mg | 600mg |
| Pentazocine | None | 243mg |
| Tramadol | 400mg IR products<br>300mg ER products | 900mg |
| Meperidine | 600mg | 900mg |
| Butorphanol | None | 12.86mg |
| Opium | 4 suppositories/day<br>Deodorized Tincture: 24mg/day<br>Camphorated Tincture: 16mg/day | 90mg |
| Benzhydrocodone | None | 73.77mg |
| Levorphanol | None | 8.18mg |

| | |
|---|---|
| □ **Yes** □ **No** | **Can the requested dose be achieved by moving to a higher strength of the product?**<br>*If yes, list reasoning for not switching:* |
| □ **Yes** □ **No** | **Does the requested dose exceed the FDA approved limit or maximum Morphine Milligram Equivalents (MME) per day (see table above)?**<br>*If yes, list reason:* |
| □ **Yes** □ **No** | **Has the patient tried and failed non-opioid pain medications?** *(If yes, complete Section D above)* |
| □ **Yes** □ **No** | **Have opioid medication doses of less than 90 MME been tried and did not adequately control pain?**<br>*(If yes, complete Section D above)* |

**CONTINUATION OF THERAPY**

| | |
|---|---|
| □ **Yes** □ **No** | **Has the prescriber identified rationale for not tapering and discontinuing opioid if treatment goals are not being met?**<br>*If yes, document rationale:* |
| □ **Yes** □ **No** | **Has the patient demonstrated meaningful improvement in pain and function when assessed against treatment goals?**<br>*If yes, document improvement in function or pain score improvement:* |

**Physician Signature:** _____ **Date:** _____