United Healthcare Community Plan

Opioids - Michigan
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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Clinical and Drug Specific Information

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

- **Risk assessment has been performed**
- **Pain Medication Agreement with informed consent has been reviewed with, completed and signed by the patient**
- **MAPS/NarxCare report has been reviewed by prescriber in last 30 days. (Please do not submit the MAPS report.) Concurrently prescribed drugs have been reviewed and that based on prescriber's assessment the drugs and doses are safe for the member**
- **Concurrently prescribed drugs have been reconciled and reviewed for safety**
- **Non-opioid pain interventions have been recommended and/or utilized (i.e., Non-opioid medications and Adjuvant therapies such as physical therapy (PT), occupational therapy (OT), behavioral therapies, or weight loss)**
- **A toxicology screen (urine or blood) from a commercial lab has been performed at appropriate intervals. Results from toxicology screen showed expected results.**
- **Patient has been counseled on obtaining and the appropriate utilization of a Narcan (naloxone) kit**
- **If applicable, the patient has been counseled on the potential increased risk of adverse effects when opioids are taken concomitantly with opioid potentiators (e.g. benzodiazepines/sedative hypnotics, stimulants, gabapentinoids, muscle relaxers)**

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 which applies)* □ Cancer diagnosis □ End-of-life care □ Hospice care □ Palliative care □ Sickle cell anemia
□ Yes □ No	**Has the patient had a therapeutic failure of <u>one week</u> each with preferred medications?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have an allergy, contraindication, drug to drug interaction, or a history of unacceptable side effects to all the preferred medications?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*

QUANTITY LIMIT
Requests for more than a 7-day supply when the patient is opioid naïve (defined as not having filled an opioid in the past 180 days)

□ Yes □ No	**Does any of the following apply to the patient?** *(If yes, check all that apply)* □ Traumatic injury □ Post-surgical procedures, excluding dental procedures □ Prescriber attests that the patient has received an opioid within the past 180 days
□ Yes □ No	**Does the prescriber attest to both of the following?** *(If yes, check all that apply)* □ 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. □ If requested for traumatic injury or post-surgical procedure, prescriber attests that based on injury or surgical procedure performed, the patient requires greater than a 7-day supply of short-acting opioid to adequately control pain.

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EXCEEDING 90 MORPHINE MILLIGRAM EQUIVALENT (MME) CUMULATIVE THRESHOLD	
□ Yes □ No	**Is there documentation outlining pain related history and physical(s) including clinical justification supporting the need for exceeding high MME?** *If yes, please document:*
□ Yes □ No	**Is there documentation of recent non-opioid medications utilized for pain management or rationale these cannot be used?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Is there documentation of all current opioid medications (long and short-acting) and when the regimen was initiated?** *If yes, please document:*
□ Yes □ No	**Is there documentation of daily morphine milligram equivalent?** *If yes, please document:*
□ Yes □ No	**Is the patient currently pregnant?** *If yes, document the name and location of the OB/GYN following this high-risk pregnancy:*
CONTINUATION OF THERAPY	
□ Yes □ No	**Is there documentation of a taper plan or rationale why taper is not appropriate?** *If yes, please document:*
BRAND ACTIQ / FENTORA / FENTANYL CITRATE BUCCAL TABLETS & LOZENGE / LAZANDA	
□ Yes □ No	**Is the requested medication being used for the management of breakthrough cancer pain in a patient established on immediate release and long-acting opioid therapy?**
□ Yes □ No	**Are the requests for controlled substances under the name and ID of the prescribing physician?**
□ Yes □ No	**Is the requested medication prescribed by a physician who is experienced in the use of Schedule II opioids?**
□ Yes □ No	**Is the current dosage regimen of the long-acting and regularly prescribed immediate-release narcotic maximally optimized?**
□ Yes □ No	**Is the requested medication being used with other inducers of cytochrome P450 concomitantly?**
□ Yes □ No	**Is the requested medication being used with other inhibitors of cytochrome P450 concomitantly?**
BELBUCA	
□ Yes □ No	**Does the patient have a diagnosis of moderate to severe chronic pain requiring around the clock opioid analgesia?**
SEGLENTIS	
□ Yes □ No	**Does the prescriber attest that Seglentis will not be used for postoperative management in children younger than 18 years of age following tonsillectomy and/or adenoidectomy?**
TRAMADOL ORAL SOLUTION	
□ Yes □ No	**Does the patient have difficulty swallowing tablets?**

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XTAMPZA ER	
□ Yes □ No	**Does the patient have a diagnosis of severe chronic pain requiring around the clock opioid analgesia?**
□ Yes □ No	**Have alternative treatment options been ineffective, not tolerated or inadequate for controlling pain?**

Provider Signature: _____ **Date:** _____