

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: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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](http://www.uhcprovider.com) for a list of preferred alternatives**

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
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**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient receiving the requested medication to treat any of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Amputation <input type="checkbox"/> Cancer pain <input type="checkbox"/> Catastrophic injury <input type="checkbox"/> End-of-life/hospice care <input type="checkbox"/> Major orthopedic surgery <input type="checkbox"/> Palliative care <input type="checkbox"/> Severe burn <input type="checkbox"/> Sickle cell <input type="checkbox"/> Traumatic crushing of tissue
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Has the patient had an inadequate clinical response to a 7-day trial of one preferred product?</b> <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient unable to be changed to a preferred medication due to any of the following?</b> <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Patient has an allergy to TWO unrelated preferred medications <input type="checkbox"/> Patient has a contraindication to, or drug-to-drug interaction with, preferred medications <input type="checkbox"/> Patient has a history of unacceptable/toxic side effects to preferred medications
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>For brand requests has the patient failed the generic product (if covered by the state)?</b> <i>(If yes, complete Section D above)</i>

**LONG-ACTING OPIOIDS**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is there documentation of a treatment plan including any of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Risk assessment <input type="checkbox"/> Substance abuse history <input type="checkbox"/> Concurrent therapies
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Was the Ohio Automated Rx Reporting System (OARRS) checked within 7 days prior to initiating long-acting therapy?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have documentation of pain and function scores at each visit?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Has patient's baseline urine drug test been submitted and treatment plan includes requirements for random urine screens?</b> <i>(DOCUMENTATION REQUIRED)</i>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient's opioid contract in place and been submitted?</b> <i>(DOCUMENTATION REQUIRED)</i>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does that patient have documented failure of both non-opioid pharmacologic and non-pharmacologic treatments?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Does the patient have a history of short-acting opioids for greater than or equal to 60 days?</b>

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<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the prescription from an oncologist or pain specialist?</b>
<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Is the patient concurrently taking a long-acting opioid at therapeutic dose (ANY of the following for greater than or equal to 1 week without adequate pain relief)?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Greater than or equal to 60 milligrams (mg) oral morphine/day <input type="checkbox"/> Greater than or equal to 25 micrograms (mcg)/hour transdermal fentanyl <input type="checkbox"/> Greater than or equal to 30 mg oral oxycodone/day <input type="checkbox"/> Greater than or equal to 8 mg oral hydromorphone/day <input type="checkbox"/> Greater than or equal to 25 mg oral oxymorphone/day <input type="checkbox"/> Equianalgesic dose of another opioid

**QUANTITY LIMIT – NEW START – SHORT-ACTING OPIOID (cont'd on the next page)**

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<b>Has the patient had a trial and failure of non-pharmacologic treatments and/or non-opioid analgesics or are non-pharmacologic treatments and/or non-opioid analgesics are ineffective or contraindicated?</b>
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## Opioid Products - Ohio Prior Authorization Request Form

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a diagnosis of somatic pain?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Have the benefits and risks of opioid therapy been discussed with the patient?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Has the prescriber checked the Ohio Automated Rx Reporting System (OARRS)?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there attestation that patient is not opioid naïve based on patient having been on a higher dose in the hospital?</b>	
<b>QUANTITY LIMIT – EXCEEDING CUMULATIVE 30 MME PER PRODUCT OR 90 MME LIMIT</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the prescriber indicate the requested dose or escalation of dose is likely to result in improved function and pain control?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Are cumulative doses greater than 100 morphine equivalent dose (MED) made in consultation with pain specialist or anesthesiologist?</b>	
<b>CONTINUATION OF THERAPY - LONG-ACTING OPIOIDS</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there a current treatment plan?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Has the patient demonstrated adherence to treatment plan through progress notes including pain and function scores and random urine screens results reviewed and concerns addressed, no serious adverse outcomes observed?</b>	

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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