UnitedHealthcare Community Plan

Opioid Products – Rhode Island
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

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

UnitedHealthcare Community Plan

Opioid Products – Rhode Island
PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

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

UnitedHealthcare Community Plan

Opioid Products – Rhode Island
PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

CANCER / HOSPICE / END-OF-LIFE RELATED PAIN	
□ Yes □ No	**Is the patient being treated for cancer related pain?** *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?** *If yes, list date regimen was started:*
NON-CANCER / NON-HOSPICE / NON-END-OF-LIFE CARE 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 patient already receiving chronic opioid therapy prior to surgery for postoperative pain, or is the postoperative pain 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)* □ Neuropathic pain (e.g. neuralgias, neuropathies, fibromyalgia) □ Non-neuropathic pain
□ Yes □ No	**For <u>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)* □ Check box if Gabapentin is contraindicated
□ Yes □ No	**For <u>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?** *(If yes, complete Section D above)* □ Check box if tricyclic antidepressant is contraindicated

QUANTITY LIMIT & EXCEEDING 90 MME CUMULATIVE THRESHOLD ***(continued on next page)***

Please note the plan's quantity limits:

Active Ingredient	FDA Label Max Daily Doses	90 MME Equivalent (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 500mg ER products	225mg
Oxymorphone	None	30mg
Oxycodone	Xtampza Only =288mg	60mg
Codeine	360mg	600mg
Pentazocine	None	243mg
Tramadol	400mg IR products 300mg ER products	900mg
Meperidine	600mg	900mg
Butorphanol	None	12.86mg
Opium	4 suppositories/day Deodorized Tincture: 24mg/day Camphorated Tincture: 16mg/day	90mg
Benzhydrocodone	None	73.77mg
Levorphanol	None	8.18mg

UnitedHealthcare Community Plan

Opioid Products – Rhode Island
PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

□ Yes □ No	**Can the requested dose be achieved by moving to a higher strength of the product?** *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)?** *If yes, list reason:*
□ Yes □ No	**Has the patient tried and failed non-opioid pain medication?** *(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?** *(If yes, complete Section D above)*
CONTINUATION OF THERAPY	
□ Yes □ No	**Has the patient demonstrated meaningful improvement in pain and function when assessed against treatment goals?** *If yes, document improvement in function or pain score improvement:*
□ Yes □ No	**Has the prescriber identified rationale for not tapering or discontinuing opioid if treatment goals are not met?** *If yes, list rationale:*

Physician Signature: _____ **Date:** _____