UnitedHealthcare Community Plan

Methadone – Virginia
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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Methadone – Virginia
Prior Authorization Request Form

Patient First name:	Patient Last name:	Patient DOB:

Clinical and Drug Specific Information	
□ Yes □ No	**Does the prescriber attest that a treatment plan has been established with the patient and includes <u>ALL</u> of the following?** • **Signed agreement with the patient** • **Established expected outcome and improvement in both pain relief and function or just pain relief as well as limitations (i.e., Function may improve yet pain persist OR pain may never be totally eliminated)** • **Established goals for monitoring progress toward patient-centered functional goals; e.g., walking the dog or walking around the block, returning to part-time work, attending family sports or recreational activities, etc.** • **Goals for pain and function, how opioid therapy will be evaluated for effectiveness and the potential need to discontinue if not effective** • **Emphasize serious adverse effects of opioids (including fatal respiratory depression and opioid use disorder, OR alter the ability to safely operate a vehicle)** • **Emphasize common side effects of opioids (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, withdrawal)** **Prescriber's Signature: _____ Date: _____**
ALL REQUESTS	
□ Yes □ No	**Is the patient an infant up to 1 year of age who was discharged from the hospital on a methadone taper?**
□ Yes □ No	**Does the prescriber attest that the patient has intractable pain associated with any of the following?** *(If yes, check which applies)* □ Active cancer □ Hospice care □ Palliative care (treatment of symptoms associated with life limiting illnesses)
□ Yes □ No	**Does the patient have any of the following diagnoses?** *(If yes, check which applies)* □ Chronic severe pain □ Metastatic neoplasia □ Sickle cell
□ Yes □ No	**Is the prescriber one of the following specialists?** *(If yes, check which applies)* □ Chronic pain specialist □ Oncologist □ Palliative care □ Sickle cell specialist
□ Yes □ No	**Does the patient have a contraindication to ALL other preferred and non-preferred long acting opioids?** *(MedWatch form must be submitted)* If yes, list contraindications:
□ Yes □ No	**Does the patient have a history of, or received treatment for, drug dependency or drug abuse?**
□ Yes □ No	**Has the prescriber checked the prescription monitoring program (PMP) website on the date of this request to determine whether the patient is receiving opioid dosages or dangerous combinations (e.g. opioids and benzodiazepines) that put the patient at risk for fatal overdose?** *If yes, list date the website was accessed:* _____
	What is the date of the patient's last opioid prescription within the last 12 months from the PMP website? _____

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	What is the date of the patient's last benzodiazepine prescription within the last 12 months from the PMP website? _____
□ **Yes** □ **No** □ **Not Applicable**	**Has the prescriber counseled the patient of the risks associated with combined use of benzodiazepines and opioids?**
	What is the patient's total morphine milligram equivalents (MME) from the PMP website? _____ per day
□ **Yes** □ **No**	**If the patient's MME per day is greater than 50, does the prescriber attest to either of the following?** *(If yes, check which applies)* □ MME/Day of 51 to 90, the prescriber considered offering a prescription for naloxone and overdose prevention education □ MME/Day > 90, the prescriber considered offering a prescription for naloxone, providing overdose prevention education, and consulting with a pain specialist
□ **Yes** □ **No**	**Has a presumptive urine drug screen (UDS) been done at least annually and checks for a minimum of 10 substances including heroin, prescription opioids, cocaine, marijuana, benzodiazepines, amphetamines, and metabolites?** *(Copy of the most recent UDS must be submitted)*
EXCEEDING 90 MME CUMULATIVE THRESHOLD	
□ **Yes** □ **No**	**Does the patient have chronic, moderate to severe pain OR severe post-operative pain?**
□ **Yes** □ **No**	**Does the prescriber attest to ALL of the following?** • **That they will be managing the patient's opioid therapy long term** • **Have reviewed the Virginia board of medicine (BOM) Regulations for Opioid Prescribing** • **Acknowledge the warnings associated with high dose opioid therapy including fatal overdose** • **That therapy is medically necessary for this patient**
□ **Yes** □ **No**	**Has the prescriber prescribed naloxone?**
□ **Yes** □ **No** □ **Not Applicable**	**If the patient is a woman between the ages of 18 to 45 years of age, has the provider counseled the patient on becoming pregnant while receiving opioids, including the risk of Neonatal Opioid Withdrawal Syndrome and offered access to contraceptive services when necessary?**
□ **Yes** □ **No**	**Has the prescriber ordered and reviewed a urine drug screen (UDS) or serum medication level at least every 3 months for the first year of treatment and at least every 6 months thereafter to ensure adherence?**

Provider Signature: _____ **Date:** _____

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