UnitedHealthcare Community Plan

Opioid Dependency – 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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Patient First name:	Patient Last name:	Patient DOB:

Clinical and Drug Specific Information	
NON-PREFERRED MEDICATIONS (BUNAVAIL, BUPRENORPHINE/NALOXONE FILM, ZUBSOLV)	
□ Yes □ No	**Does the patient have a diagnosis of Opioid Use Disorder as defined by DSM 5 (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition)?**
□ Yes □ No	**Has the prescriber reviewed the Virginia PMP (Prescription Monitoring Program) before the initiation of therapy?**
□ Yes □ No	**Is the patient taking ANY of the following medications: benzodiazepines, opioids, sedative hypnotics, tramadol, carisoprodol?** *If yes, list medication(s) patient is taking:*
□ Yes □ No	**If yes to the above question, has the provider documented extenuating circumstances that necessitate the co-prescribing of these medications AND documented in the medical record a tapering plan to achieve the lowest possible effective doses of these medications?** *If yes, list extenuating circumstances and documented taper plan:*
□ Yes □ No	**Is there a clinical reason why the patient cannot use a preferred agent?** **NOTE: A completed FDA (Food and Drug Administration) MedWatch form is required to be attached for adverse reactions to combination products.** *If yes, list clinical reason:*
CONTINUATION OF THERAPY	
□ Yes □ No	**Is the prescriber checking random urine drug screens as part of the treatment plan?**
□ Yes □ No	**If yes to the above question, does the urine screen check for ALL of the following: Amphetamine/methamphetamine, Benzodiazepines, Buprenorphine, Cocaine, Heroin, Methadone, Norbuprenorphine, Oxycodone, THC, Other prescription opiates?**
BUPRENORPHINE SUBLINGUAL TABLETS	
□ Yes □ No	**Is the patient pregnant?**
□ Yes □ No	**If yes to the above question, is there documentation of a positive pregnancy test along with expected date of delivery?** *If yes, list expected date of delivery:*
QUANTITY LIMITS	
□ Yes □ No	**Has the provider submitted clinical rationale including documentation of why this higher dose is medically necessary?** *If yes, list rationale:*

Provider Signature: _____ **Date:** _____