UnitedHealthcare
Community Plan

Opioid Products – 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

UnitedHealthcare Community Plan

Opioid Products – Virginia
Prior Authorization Request Form

Patient First name:	Patient Last name:	Patient DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
☐ **Yes** ☐ **No**	**Does the patient meet any of the following conditions or care instances?** *(If yes, check which applies)* ☐ Active cancer related pain ☐ Breakthrough cancer pain ☐ Chronic, moderate to severe pain ☐ Hospice care or end of life care ☐ In remission from cancer and the prescriber is safely weaning patient off of opioids with a tapering plan ☐ Long term care (LTC) facility ☐ Palliative care (treatment of symptoms associated with life limiting illnesses) ☐ Severe post-operative pain ☐ Sickle cell disease
	What is the patient's active daily morphine milligram equivalents (MME) from the prescription monitoring program (PMP) website? ______________
	What is the date of the patient's last opioid prescription from the PMP website? ___________
	What is the date of the patient's last benzodiazepine prescription from the PMP website? _________
☐ **Yes** ☐ **No**	**Has the prescriber ordered and reviewed a urine drug screen (UDS) or serum medication level prior to initiating treatment with the requested medication?**
☐ **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?**
☐ **Yes** ☐ **No**	**Does the prescriber attest that a treatment plan with goals that addresses benefits and harm has been established with the patient?**
☐ **Yes** ☐ **No**	**Is the patient established on pain therapy with the requested medication for cancer-related pain or palliative care pain, AND the medication is not a new regimen for treatment of cancer-related pain or palliative care pain?** *If yes, list date regimen was started:*
☐ **Yes** ☐ **No**	**Does the patient require continuous around-the-clock analgesia therapy?**
☐ **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 naloxone been prescribed for patients with any of the following risk factors?** *(If yes, check which applies. If no, list reason below)* ☐ Concomitant antihistamines ☐ Concomitant antipsychotics ☐ Concomitant benzodiazepine use ☐ Concomitant gabapentin ☐ Concomitant pregabalin ☐ Concomitant tricyclic antidepressants ☐ Concomitant "Z" drugs (eszopiclone, zolpidem, or zaleplon) ☐ Doses in excess of 50 MME/day ☐ Substance use disorder *List reason:*

UnitedHealthcare Community Plan

Opioid Products – Virginia
Prior Authorization Request Form

Patient First name:	Patient Last name:	Patient DOB:

☐ Yes ☐ No	**Has the patient tried any of the following?** *(If yes, check which applies and complete "Previous Medication Trials/Contraindications" section on first page)* ☐ Baclofen ☐ Capsaicin gel ☐ Cognitive behavioral therapy ☐ Duloxetine ☐ Gabapentin ☐ Lidocaine 5% patch ☐ NSAIDs (oral) ☐ Physical therapy ☐ Tricyclic antidepressants
☐ Yes ☐ No	**Requests for short-acting opioids:** **Does the patient have a history of contraindication, drug-drug interaction with, or toxic side effects that cause immediate or long-term damage from at least TWO preferred products?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
☐ Yes ☐ No	**Requests for long-acting opioids:** **Does the patient have a history of contraindication, drug-drug interaction with, or toxic side effects that cause immediate or long-term damage from any of the following?** *(If yes, check which applies and complete "Previous Medication Trials/Contraindications" section on first page)* ☐ Butrans (buprenorphine) transdermal ☐ Morphine sulfate controlled release tablets (specifically generic MS Contin) ☐ Preferred fentanyl transdermal
☐ Yes ☐ No	**Requests for Tramadol 100mg tablets:** **Is there rationale for needing to use the 100 mg tramadol tablet instead of two 50 mg tramadol tablets?** *If yes, document rationale:*
☐ Yes ☐ No	**Requests for Qdolo:** **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 "Previous Medication Trials/Contraindications" section on first page)* ☐ Patient is unable to swallow a solid dosage form ☐ Patient utilizes a feeding tube for medication administration
EXCEEDING 90 MME CUMULATIVE THRESHOLD	
☐ 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?**

Provider Signature: ______________________________ **Date:** ______________

Confidentiality Notice: This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.