

**Morphine Extended-Release [ER] Capsule
Long-Acting Opioid Prior Authorization Request Form (Page 1 of 3)**

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
For states, such as AR, that have a terminal illness mandate, and for patients who have a terminal illness, please answer the following:					
Will the requested medication be used for the treatment of a terminal condition or associated symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "YES", please indicate the patient's estimated life expectancy: <input type="checkbox"/> Less than 6 months <input type="checkbox"/> Less than _____ months (please specify)					
Select all the applicable diagnoses below :					
<input type="checkbox"/> Cancer or end of life related pain					
<input type="checkbox"/> Moderate to severe chronic pain that is non-neuropathic					
<input type="checkbox"/> Moderate to severe neuropathic pain or fibromyalgia (examples of neuropathic pain include neuralgias, neuropathies)					
<input type="checkbox"/> Other diagnosis: _____					
For diagnosis of cancer or end of life (defined as a < 2 years life expectancy) related pain, please answer the following:					
Does the patient have an active cancer diagnosis or life expectancy of < 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will medical records documenting an active cancer diagnosis or life expectancy of < 2 years be submitted to ProAct® with this fax form? <input type="checkbox"/> Yes <input type="checkbox"/> No					
***Please note: Medical records documenting an active cancer diagnosis or life expectancy of < 2 years is required to be submitted along with this fax form. ***					
For diagnosis of moderate to severe chronic pain that is non-neuropathic, please answer the following:					
Is the requested medication being used as an as-needed (PRN) analgesic? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the requested medication being used for pain that is mild or not expected to persist for an extended period of time? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the requested medication being used for acute pain? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the requested medication being used for postoperative pain? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please answer the following:					
• Has the patient already received chronic opioid therapy prior to surgery or is the postoperative pain expected to be moderate to severe and persist for an extended period of time? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Prior to the start of therapy with the requested long-acting opioid, has the patient failed an adequate trial of a short-acting opioid? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes , please document the name of the medication(s), date, and duration of trial:					
Medication: _____ Date of trial: _____ Duration of trial: _____					
For diagnosis of moderate to severe neuropathic pain or fibromyalgia, please answer the following:					
Does the patient have a contraindication to or has not exhibited an adequate response to treatment with gabapentin titrated to a therapeutic dose? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please document dose, date, and duration of trial					
Dose: _____ Date of trial: _____ Duration of trial: _____					
Does the patient have a contraindication to or has not exhibited an adequate response to treatment with a tricyclic antidepressant titrated to the maximum tolerated dose? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please document drug, dose, date and duration of trial:					
Medication: _____ Dose: _____ Date of trial: _____ Duration of trial: _____					

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Select the medications the patient has a history of failure, contraindication, or intolerance to (Document date and duration of trials):		
<input type="checkbox"/> Fentanyl transdermal patch (generic Duragesic)	Date: _____	Duration of trial: _____
<input type="checkbox"/> Morphine sulfate controlled-release tablet (generic MS Contin)	Date: _____	Duration of trial: _____
<input type="checkbox"/> Nucynta ER	Date: _____	Duration of trial: _____
<input type="checkbox"/> Xtampza ER	Date: _____	Duration of trial: _____

Reauthorization [Non-cancer and non-end of life pain only]:
If this is a reauthorization request, please answer all of the following questions:

1. What are the treatment goals for this patient? (Document treatment goals) _____

2. What alternative nonopioid analgesic and/or nonpharmacologic interventions are currently being used with this requested medication? (Document other treatment interventions) _____

3. Has the patient demonstrated meaningful improvement in pain scale score? (Document score) Yes No _____

4. What is the patient's most recent score on a substance abuse/opioid dependence risk assessment tool? (Document score) _____

5. What is the rationale for not tapering and discontinuing the requested medication? (Document rationale) _____

6. What comorbid mental health conditions has the patient been screened for? (Document mental health conditions for which the patient has been screened) _____

7. Has the state's prescription drug monitoring program (PDMP) been reviewed for this patient? Yes No None in state
 What other controlled substances is the patient currently receiving? _____

8. Has the patient been assessed for risk of respiratory depression from medical comorbidities or the concurrent use of benzodiazepines or other drugs causing drug-drug interactions and the prescriber acknowledges that they have completed an assessment of increased risk for respiratory depression? Yes No _____

9. What is the patient's total daily dose? _____

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Quantity limit requests:

What is the quantity requested per DAY? _____

For diagnosis of cancer related pain or who are end of life (life expectancy < 2 years), please answer the following:

Can the requested dose be achieved by moving to a higher strength dosage form? Yes No

For diagnosis of non-cancer or non-end of life related pain, please answer the following:

Does the requested dose exceed 90 morphine equivalent doses (MED) daily? Yes No

Example of 90 MED equivalent: Morphine ER capsule (generic Avinza) = 90mg/day

Can the requested dose be achieved by moving to a higher strength dosage form? Yes No

What is the reason for exceeding the plan limitations?

- Titration or loading-dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- Other: _____

Prescriber attestation:

Does the prescriber attest that the information provided is true and accurate to the best of their knowledge and understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided? Yes No

Prescriber's signature: _____ Date: _____

Please note: All information must be completed and chart documentation (i.e., chart notes) [where applicable] must be submitted to Optum Rx.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ Date: _____

PROACT INTERNAL USE ONLY:

Clinical Review Decision

Approved, through

Denied (documentation attached, if necessary)

Tracking:

1st Attempt

2nd Attempt

Letter Mailed:



1230 US Highway 11

Gouverneur, NY 13642

Phone: 1-877-635-9545

Prior Authorization Fax: 1-844-712-8129