UnitedHealthcare Community Plan

# NC Pharmacy Prior Approval Request for Short-Acting Opioid Analgesic

**Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender:_____

**Prescriber Information**

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

**Drug Information**

8. Drug Name:_____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ Other: _____

**Clinical Information**

1. Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ☐ **Yes** ☐ **No** If yes, the patient is exempt from the prior authorization requirement
2. Does the patient have Sickle Cell Disease? ☐ **Yes** ☐ **No**
3. Is this an initial authorization request? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request. ☐ **Yes** ☐ **No**
   3a. If No, please attach documentation as to why the beneficiary needs continued opioid treatment and current plan of care.
4. **Is the requested daily dose *in combination with other concurrent opioids* less than or equal to 90mg of morphine or an equivalent dose?** ☐ **Yes** ☐ **No** Answer questions 3a and 3b when the response to question 3 is 'No'.
   4a. Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits.
   Please list: _____.
   4b. Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose.
   Please list: _____
5. Has the prescriber reviewed and is adhering to the N.C. Medical Board statement on the use of controlled substances for the treatment of pain? ☐ **Yes** ☐ **No**
6. Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate? ☐ **Yes** ☐ **No**
7. Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System? ☐ **Yes** ☐ **No**
8. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? ☐ **Yes** ☐ **No**

**Non-Preferred Products:**

9. Does the patient have a documented history within the past year of two preferred long-acting Opioid Analgesics at a dose equal to or equivalent to the non-preferred long-acting Opioid Analgesic being prescribed? ☐ **Yes** ☐ **No**
   Please list: _____
10. Does the patient have a contraindication or allergy to ingredients in the preferred product? ☐ **Yes** ☐ **No**
    Please list: _____

Signature of Prescriber: _____ Date: _____

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center: 1-855-258-1593