HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
CHRONIC OPIOID MEDICATIONS
Chronic Opioid Medications

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of active cancer with cancer-related pain, is enrolled in hospice, or meets hospice criteria? If yes, no further assessment is required.	☐	☐	**Please provide documentation**
2. Will the requested therapy exceed 200 morphine milligram equivalents (MME) per day? **If yes, an active taper plan is required for authorization.**	☐	☐	**Please provide taper plan**
3. Does documentation show that non-pharmacologic treatments such as physical therapy, cognitive behavioral therapy, etc. have been tried but are inadequate?	☐	☐	**Please provide documentation**
4. Does documentation show a trial and failure of non-opioid medications (e.g., acetaminophen, NSAIDs, antidepressants, muscle relaxants, topical analgesics, etc.)?	☐	☐	**Please provide documentation, including names, dates, and durations of treatments**
5. Does the member's pain impact their ability to perform activities of daily living and/or is causing significant psychological issues?	☐	☐	**Please provide documentation**
6. Is there a treatment plan in place that outlines the goals of therapy and how the member's progress will be evaluated (e.g., pain levels, functional status, etc. from baseline)?	☐	☐	**Please provide documentation**
7. Has the member signed a pain contract or informed consent and treatment agreement for chronic opioid therapy?	☐	☐	**Please provide documentation**

8. Does documentation show that the prescriber has monitored the member's urine drug screen results within the last 12 months?	☐	☐	**Please provide documentation**
9. Has the member been offered a prescription and training for nasally administered naloxone?	☐	☐	
10. Is the requested therapy for opioid addiction treatment?	☐	☐	**Please provide documentation**
11. Is the member being treated with duplicate short-acting opioids? **Documentation showing that a single short-acting agent is not sufficient or appropriate, is required.**	☐	☐	**Please provide documentation**
12. Is the member also being treated with a benzodiazepine (e.g., lorazepam, alprazolam, etc.)? **Documentation showing medical necessity is required.**	☐	☐	**Please provide documentation**
13. Is the member also being treated with carisoprodol (Soma)? **Opioid treatment in combination with carisoprodol will not be covered**	☐	☐	**Please provide documentation**
14. Is the prescriber reviewing the member's history of controlled substance prescriptions using the states prescription drug monitoring program at least every 3 months?	☐	☐	**Please provide documentation**
LONG ACTING OPIOIDS			
1. Is the request for a long-acting opioid?	☐	☐	
2. Does the member require daily, around-the-clock long-term opioid treatment?	☐	☐	**Please provide documentation**
3. Has the member tried and failed short-acting opioids along with non-pharmacological therapy?	☐	☐	**Please provide documentation**
4. Is the member currently on opioid therapy that is at least 20 MMEs per day?	☐	☐	**Please provide documentation**
5. Does the member have a past or current substance abuse potential? **Documentation showing medical necessity for opioid treatment is required.**	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member shown objective progress toward treatment plan goals?	☐	☐	**Please provide documentation**
3. Has the member continued to utilize physical, behavioral, and non-opioid therapies in combination with chronic opioid therapy?	☐	☐	**Please provide documentation**
4. Has a random drug screen been performed within the past 12 months?	☐	☐	**Please provide documentation**
5. Do the member's medication records correspond with medical reasons for continuing or modifying opioid therapy (i.e., medication, dose, and quantities prescribed)?	☐	☐	

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

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Policy PHARM-051
Origination Date: 08/21/2017
Reviewed/Revised Date: 03/05/2020
Next Review Date: 01/23/2021
Current Effective Date: 03/05/2020