HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
OPIOID LIMITATIONS

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.

Acute opioid coverage is limited to 7 days of therapy within any 60 days. Quantity limits and dose limits apply for acute opioid therapy. Long-acting opioids are not covered for acute use. Requests for therapy exceeding 7 days require the following documentation.

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 cancer, cancer-related pain, or is enrolled in hospice or meets hospice criteria? **If documentation supports active cancer therapy, no additional questions are required.**	☐	☐	**Please provide documentation**
2. Will the requested therapy exceed 200 morphine milligram equivalents (MME) per day? If yes, a taper plan is required for authorization.	☐	☐	**Please provide taper plan if total opioid dose is greater than 200 MME/day.**
3. Does documentation show that non-pharmacologic treatments such as physical therapy, cognitive behavioral therapy, etc. have been tried and failed?	☐	☐	**Please provide documentation**
4. Does documentation show a trial and failure of non-opioid medications (i.e. acetaminophen, NSAIDs, antidepressants, muscle relaxants, topical analgesic, 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 (i.e. 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. Does documentation show that prescriber has monitored the state Department of Public Licensure Controlled Substance Database at each visit?	☐	☐	**Please provide documentation**
10. Has the member been offered a prescription and training for nasally administered naloxone?	☐	☐	
11. Is the member being treated for opioid addiction?	☐	☐	**Please provide documentation**
12. Is the member also being treated with a benzodiazepine (i.e. lorazepam, alprazolam, etc.)? Documentation showing medical necessity is required.	☐	☐	**Please provide documentation**
13. Is the member taking carisoprodol in combination with opioids? **(Dual therapy with carisoprodol and opioids is not allowed).**	☐	☐	
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 MME's per day?	☐	☐	**Please provide documentation**
5. Does the member have a past or current substance abuse potential? **Documentation showing medical necessity 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)?	☐	☐	**Please provide documentation**
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's Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- 052
Origination Date: 08/21/2017
Reviewed/Revised Date: 08/19/2020
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Current Effective Date: 09/01/2020