



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations. Visit go.covermymeds.com/OptumRx to begin using this free service. Please note: All information below is required to process this request. Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Belbuca® Prior Authorization Request Form (Page 1 of 2)
DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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)
<p>For states, such as GA and AR, that have a terminal illness mandate, and for patients who have a terminal illness, please answer the following:</p> <p>Will the requested medication be used for the treatment of a terminal condition or associated symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "YES", please indicate the patient's estimated life expectancy:</p> <p><input type="checkbox"/> Less than 6 months <input type="checkbox"/> Less than 24 months <input type="checkbox"/> Less than ____ months (please specify)</p> <p>Select the diagnosis below:</p> <p><input type="checkbox"/> Cancer related pain OR pain associated with end of life</p> <p><input type="checkbox"/> Non-cancer pain</p> <p><input type="checkbox"/> Other diagnosis: _____ <input type="checkbox"/> ICD-10 Code(s): _____</p> <p>For diagnosis of non-cancer pain, please answer the following:</p> <p>Is the patient being treated for pain severe enough to require daily, around-the-clock, longer-term opioid treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the requested medication being used as an as-needed (PRN) analgesic? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>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</p> <p>Is the requested medication being used for acute pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the requested medication being used for opioid dependence? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the patient receiving other long-acting opioids concurrently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Belbuca[®] Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Reauthorization [Non-cancer 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 and estimated duration of treatment) _____
2. Does the treatment plan include the use of a non-opioid analgesic and/or non-pharmacologic intervention? Yes No
3. Has the patient demonstrated meaningful improvement in pain and function using a validated instrument (e.g., Brief Pain Inventory)? Yes No
4. Has the patient been screened for substance abuse/opioid dependence using a validated instrument (e.g., DAST-10)? Yes No
5. What is the rationale for not tapering and discontinuing the requested medication? (Document rationale) _____
6. Has the patient been screened for comorbid mental health conditions? Yes No
7. Is there a state prescription drug monitoring program (PDMP) available? Yes No
If **yes**, has the prescriber identified that there are NO concurrently prescribed controlled substances from the PDMP? Yes No
8. Does the prescriber acknowledge that he/she has completed an assessment of increased risk for respiratory depression in patients who have medical comorbidities or are using concurrent benzodiazepine/other drugs that could potentially cause drug-drug interactions? Yes No
9. What is the patient's total daily morphine equivalent dose? _____

Quantity limit requests:

What is the quantity requested per DAY? _____

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: _____

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.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.