Please note: All information below is required to process this request
Mon-Fri: 5am to10pm Pacific / Sat: 6am to 3pm Pacific
For real time submission 24/7 visit www.OptumRx.com and click Health Care Professionals
OptumRx • M/S CA 106-0286 • 3515 Harbor Blvd. • Costa Mesa, CA 92626

Xtampza ER® Long-Acting Opioid Prior Authorization Request Form (Page 1 of 3)

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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:
❑ Check if requesting **brand**	Is the physician supplying the medication? ❑ **Yes** ❑ **No**	
Directions for Use:	**Continuation of therapy?** ❑ **Yes** ❑ **No** If "**YES**", answer the following: Has member been on this medication in the last 180 days?* ❑ **Yes** ❑ **No** Does the prescriber confirm that the medication has been effective in treating the member's medical condition?* ❑ **Yes** ❑ **No**	

Clinical Information (required)

Your patient's pharmacy benefit program is administered by UnitedHealthcare, which uses OptumRx for certain pharmacy benefit services. Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

For states, such as GA and AR, that have a terminal illness mandate, and for members 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? ❑ **Yes** ❑ **No**

If "YES", please indicate the member's estimated life expectancy:

❑ Less than 6 months ❑ Less than 24 months ❑ Less than ____ months (please specify)

Please answer the following*:

Is the member **currently** taking the requested long-acting opioid? ❑ **Yes** ❑ **No**

Select all the applicable diagnoses below:

❑ Cancer or end of life related pain
❑ Moderate to severe chronic pain that is non-neuropathic
❑ Moderate to severe neuropathic pain or fibromyalgia (examples of neuropathic pain include neuralgias, neuropathies)
❑ 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 member have an active cancer diagnosis or life expectancy of < 2 years? ❑ **Yes** ❑ **No**

Will medical records documenting an active cancer diagnosis or life expectancy of < 2 years be submitted to *OptumRx*® with this form? ❑ **Yes** ❑ **No**

****Please note: Medical records documenting an active diagnosis of cancer or life expectancy of < 2 years is required to be submitted along with this fax. ****

For diagnosis of moderate to severe chronic pain that is non-neuropathic, please answer the following*:

Is the medication being used as an as-needed (PRN) analgesic? ❑ **Yes** ❑ **No**

Is the medication being used for pain that is mild or not expected to persist for an extended period of time? ❑ **Yes** ❑ **No**

Is the medication being used for acute pain? ❑ **Yes** ❑ **No**

Is the medication being used for postoperative pain? ❑ **Yes** ❑ **No** If **yes**, answer the following:

- Has the member 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? ❑ **Yes** ❑ **No**

Prior to the start of therapy with the long-acting opioid, has the member failed an adequate trial of a short-acting opioid? ❑ **Yes** ❑ **No**

If **yes**, please document the name of the medication(s), date, and duration of trial:

Medication:_________________________ Date of trial: ____________________ Duration of trial: ____________________

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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For diagnosis of moderate to severe neuropathic pain or fibromyalgia, please answer the following*:

Does the member have a contraindication to or has not exhibited an adequate response to treatment with gabapentin titrated to a therapeutic dose? ❑ **Yes** ❑ **No** If **yes**, please document dose, date, and duration of trial

Dose: ________________ Date of trial: ________________ Duration of trial: ________________

Does the member have a contraindication to or has not exhibited an adequate response to treatment with a tricyclic antidepressant titrated to the maximum tolerated dose? ❑ **Yes** ❑ **No** If **yes**, please document drug, dose, date, and duration of trial:

Medication: ___________________ Dose: ______________ Date of trial: ______________ 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 member? (Document treatment goals) ____
   ____

2. What alternative nonopioid and nonpharmacologic interventions are currently being used with this medication? (Document other treatment interventions) ____
   ____

3. Has the member demonstrated meaningful improvement in pain scale score? (Document score) ❑ **Yes** ❑ **No** _______________
   ____

4. What is the member'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 member been screened for? (Document mental health conditions for which the member has been screened) ____
   ____

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

8. Has the member 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 member's total daily dose? ____
   ____

Quantity limit requests*:

What is the quantity requested per MONTH? ________

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

Please provide the cancer diagnosis: _______________________

Please provide the life expectancy:_________________________

Is the member opioid tolerant who has diagnosis of pain severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative treatment options are inadequate? ❑ **Yes** ❑ **No**

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 dose exceed 90 morphine equivalent doses (MED) daily? ❑ **Yes** ❑ **No**

Example of 90 MED equivalent: Xtampza ER = 54mg/day

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

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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 OptumRx.

*May not apply to all plans

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 within established timelines.**
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.

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