Optum Rx®

Optum Rx 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

Opioids & Medication Limits Prior Authorization Request Form (Page 1 of 3)

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	

Clinical Information (required)

Answer ALL questions on this page for ALL requests

What is the patient's diagnosis for the medication being requested? _____

_____

ICD-10 Code(s): _____

What medication(s) has the patient tried and had an inadequate response to? (Please specify ALL medication(s)/strengths tried, length of trial, and reason for discontinuation of each medication)

What medication(s) does the patient have a contraindication or intolerance to? (Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)

Cancer Pain/Sickle Cell Disease/End of life care (palliative care):

Is the requested drug being prescribed for pain associated with **active** cancer, sickle cell disease or end of life/palliative care? ❑ **Yes** ❑ **No**

Is the patient currently enrolled in hospice? ❑ **Yes** ❑ **No**

Does the provider confirm that the opioid is NOT used to manage symptoms associated with the patient's terminal condition or condition(s) related to the terminal illness? ❑ **Yes** ❑ **No**

Is the prescriber affiliated with the hospice provider? ❑ **Yes** ❑ **No**

If the prescriber is NOT affiliated with the hospice provider, does the prescriber attest coordination with the hospice provider confirming that the medication is unrelated to the terminal illness or related conditions? ❑ **Yes** ❑ **No**

Long Term Care facility:

Is the patient in a long-term care facility (e.g., hospital or skilled nursing facility where patient is receiving skilled nursing care)? ❑ **Yes** ❑ **No**

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Opioid Care Management & Morphine Milligram Equivalent Requests

At the time of dispensing, high cumulative opioid dosing has been identified prompting a safety review. This review is to ensure the cumulative opioid utilization is safe and appropriate for your patient. The cumulative morphine milligram equivalent (MME) value is calculated based on the number of opioid drugs prescribed ***by one or more prescribers*** *over a period of time. The MME value includes incoming claims and claim history.* ***Your patient has exceeded the established daily cumulative MME dosage and is receiving opioid drugs from 2 or more prescribers.***

Opioid Care Coordination: For cumulative opioid doses between 90-200 MME

Does the provider attest that in his/her clinical judgment, the requested current cumulative dosage exceeding 90 Morphine Milligram Equivalent (MME) is medically necessary? ❑ **Yes** ❑ **No**

Cumulative MME: For cumulative opioid dosage greater than 200 MME

Does the provider attest that in his/her clinical judgment, the current daily Morphine Milligram Equivalent (MME) dosage exceeding the current daily MME threshold is medically necessary? ❑ **Yes** ❑ **No**

Will there be a dose escalation in the patient's opioid utilization in the next 90 days? ❑ **Yes** ❑ **No**

7 Day Supply Limit Requests

At the time of dispensing, your patient was identified as new to opioid therapy. They are allowed a 7 day supply for a first fill based on a lack of previous history over a 120 day period, prompting a safety review. This review is to ensure the opioid utilization is safe and appropriate for your patient. ***Your patient has exceeded the initial 7 day supply limit.***

Provider attestation:

Does the provider attest that in his/her clinical judgment, the requested day supply exceeding the current 7 day supply limit is medically necessary? ❑ **Yes** ❑ **No**

Does the provider attest that in his/her clinical judgment, the requested day supply exceeding the current 7 day supply limit is medically necessary because the patient will be on an intermittent schedule (e.g., the patient will have multiple surgeries during the year where a 10-day course of opioid therapy is needed with each surgery)? ❑ **Yes** ❑ **No**

Concurrent use of opioids plus benzodiazepines

At the time of dispensing, your patient was identified as utilizing an opioid AND a benzodiazepine, prompting a safety review. This review is to ensure the opioid utilization is safe and appropriate for your patient. ***Your patient is taking both an opioid and a benzodiazepine.***

Provider attestation:

Does the provider attest that in his/her clinical judgment, the requested concurrent use of opioid plus benzodiazepine, is safe and medically necessary? ❑ **Yes** ❑ **No**

Does the provider attest that either the benzodiazepine or opioid drug interacting with each other will be discontinued? ❑ **Yes** ❑ **No**

Duplicate long-acting opioid use

At the time of dispensing, your patient was identified as utilizing 2 or more long-acting opioids concurrently, prompting a safety review. This review is to ensure the opioid utilization is safe and appropriate for your patient. ***Your patient is currently on 2 or more long-acting opioids.***

Provider attestation:

Does the provider attest that in his/her clinical judgment, the overlap of two or more long-acting opioid therapy, is medically necessary? ❑ **Yes** ❑ **No**

Does the provider attest that therapy will change to include only one long-acting opioid drug? ❑ **Yes** ❑ **No**

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Opioids & Medication Limits Prior Authorization Request Form (Page 3 of 3)

Concurrent use of opioids plus buprenorphine used for Medication-Assisted-Treatment (MAT)

At the time of dispensing, your patient was identified as utilizing an opioid plus a buprenorphine containing product (used for MAT of opioid dependence) concurrently, prompting a safety review. This review is to ensure the opioid utilization is safe and appropriate for your patient. ***Your patient is currently on an opioid plus a buprenorphine containing product.***

Provider attestation:

Does the provider attest that in his/her clinical judgment, the requested concurrent use of opioid plus buprenorphine containing products (used for medication-assisted treatment of opioid dependence), is safe and medically necessary for this patient? ❑ **Yes** ❑ **No**

Does the provider attest that either the buprenorphine or opioid drug interacting with each other will be discontinued? ❑ **Yes** ❑ **No**

Acetaminophen doses exceeding 4 grams per day

Note: *If the patient exceeds the maximum FDA approved dosing of 4 grams of acetaminophen per day because he/she needs extra medication due to reasons such as going on a vacation, replacement for a stolen medication, provider changed to another medication that has acetaminophen, or provider changed the dosing of the medication that resulted in acetaminophen exceeding 4 grams per day,* ***please have the patient's pharmacy contact the Optum Rx Pharmacy Helpdesk at (800) 788-7871 at the time they are filling the prescription for a one-time override.***

Quantity Limits

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
❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**:_____

Does the patient's diagnosis include malignant (cancer) pain? ❑ **Yes** ❑ **No**

Was the requested medication prescribed by a pain specialist or by pain management consultation? ❑ **Yes** ❑ **No**

Is the requested medication being used to treat postoperative pain? ❑ **Yes** ❑ **No**

If Yes, answer the following**:**

Is the requested medication being prescribed for pain related to a dental procedure? ❑ **Yes** ❑ **No**

Is the requested dose being prescribed the same dose that the patient was stable on prior to discharge? ❑ **Yes** ❑ **No**

Select all of the following that have been maintained and documented in chart notes*:

❑ A description of the nature and intensity of the pain
❑ An appropriate patient medical history and physical examination
❑ An updated, comprehensive treatment plan (the treatment plan should state objectives that will be used to determine treatment success, such as pain relief or improved physical and/or psychosocial function)
❑ Appropriate dose escalation
❑ Ongoing, periodic review of the course of opioid therapy
❑ Verification that the risks and benefits of the use of the requested drug have been discussed with the patient, significant other(s), and/or guardian

Chart documentation:

Will chart documentation be submitted to *Optum Rx*® with this form, confirming the above information? ❑ **Yes** ❑ **No**

**Please note: Chart documentation of the above is required to be submitted for quantity limit requests for this drug.*

Please note: **This request may be denied unless all required information is received within established Medicare timelines.**
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-844-403-1028.