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

Butrans® & buprenorphine patch 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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

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:

Will the requested medication be used for the treatment of a terminal condition or associated symptoms? ❑ **Yes** ❑ **No**

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

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

Select the diagnosis below:

❑ Cancer related pain OR pain associated with end of life

❑ Non-cancer pain

❑ Other diagnosis: _____ ❑ ICD-10 Code(s):_____

For diagnosis of non-cancer pain, please answer the following:

Is the patient being treated for pain severe enough to require daily, around-the-clock, longer-term opioid treatment? ❑ **Yes** ❑ **No**

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

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

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

Is the requested medication being used for opioid dependence? ❑ **Yes** ❑ **No**

Is the patient receiving other long-acting opioids concurrently? ❑ **Yes** ❑ **No**

Butrans® & buprenorphine patch Prior Authorization Request Form (Page 2 of 2)

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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 MONTH? _____

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.