



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)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>					
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 <small>(required)</small>					
Select the diagnosis below: <input type="checkbox"/> Severe pain requiring continuous, around-the-clock opioid analgesic for an extended period of time <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
If the patient has End-Stage Renal Disease (ESRD), select all that apply: <input type="checkbox"/> The medication is being used to treat one of the following: Graft site pain or pain medication overdose <input type="checkbox"/> The dialysis provider (i.e., nephrologist, nurse practitioner, physician assistant, or dialysis center) receives a monthly capitation payment to manage the ESRD patient's care					
Select the medications the patient has a failure, contraindication, or intolerance to: <input type="checkbox"/> Belbuca <input type="checkbox"/> Buprenorphine 5 mcg/hr patch <input type="checkbox"/> Buprenorphine 7.5 mcg/hr patch <input type="checkbox"/> Buprenorphine 10 mcg/hr patch <input type="checkbox"/> Buprenorphine 15 mcg/hr patch <input type="checkbox"/> Buprenorphine 20 mcg/hr patch <input type="checkbox"/> Butrans <input type="checkbox"/> Tramadol ER (generic Ultram ER) <input type="checkbox"/> Tramadol extended-release (ER) (generic Ryzolt)					
Quantity limit requests: What is the quantity requested per MONTH? _____ Does the patient's diagnosis include malignant (cancer) pain? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the medication being used to treat postoperative pain? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, answer the following: Is the medication being prescribed for pain related to a dental procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the requested dose being prescribed the same dose that the patient was stable on prior to discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the medication prescribed by a pain specialist or by pain management consultation? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select all of the following that have been maintained and documented in chart notes*: <input type="checkbox"/> A description of the nature and intensity of the pain <input type="checkbox"/> An appropriate patient medical history and physical examination <input type="checkbox"/> 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) <input type="checkbox"/> Appropriate dose escalation <input type="checkbox"/> Ongoing, periodic review of the course of opioid therapy <input type="checkbox"/> 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 <i>OptumRx</i> ® with this form, confirming the above information? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>*Please note: Chart documentation of the above is required to be submitted for quantity limit requests for this drug.</i>					

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.**

Office use only: Butrans-buprenorphinePatch_CMS_2019Mar-W



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

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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.
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 1-800-527-0531.