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

Dilaudid® (hydromorphone) Prior Authorization Request Form (Page 1 of 2)

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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**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate
❑ Other diagnosis: ______________________________ ICD-10 Code(s): ____________________________________

If the patient has End-Stage Renal Disease (ESRD), select all that apply:
❑ The medication is being used to treat one of the following: graft site pain or pain medication overdose
❑ 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:

❑ Codeine sulfate	❑ Ibudone	❑ Oxycodone-aspirin
❑ Hydrocodone-acetaminophen (APAP) 300mg	❑ Lorcet	❑ Oxycodone-ibuprofen
❑ Hydrocodone-APAP 325mg	❑ Lorcet HD	❑ Oxymorphone IR
❑ Hydrocodone-ibuprofen 5-200mg	❑ Lorcet Plus	❑ Primlev
❑ Hydrocodone-ibuprofen 7.5-200mg	❑ Morphine sulfate IR	❑ Vicodin
❑ Hydrocodone-ibuprofen 10-200mg	❑ Nucynta	❑ Vicodin ES
❑ Hydromorphone liquid	❑ Oxycodone IR	❑ Vicodin HP
❑ Hydromorphone tablet	❑ Oxycodone-APAP	❑ Zamicet

Quantity limit requests:
What is the quantity requested per DAY? ______
Does the patient's diagnosis include malignant (cancer) pain? ❑ **Yes** ❑ **No**
Is the medication being used to treat postoperative pain? ❑ **Yes** ❑ **No**
If yes, answer the following**:**
Is the 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**
Was the medication prescribed by a pain specialist or by pain management consultation? ❑ **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 *OptumRx®* 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.*

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.**

Dilaudid® (hydromorphone) 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.

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