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

Nucynta® ER 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)

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

Clinical Information (required)

Select the diagnosis below:

❑ Severe neuropathic pain associated with diabetic peripheral neuropathy (DPN) in patients requiring daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate
❑ Severe pain in patients requiring daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Embeda
❑ Fentanyl patch
❑ Hydromorphone extended-release (ER)
❑ Hysingla ER
❑ Kadian
❑ Levorphanol
❑ Morphabond ER
❑ Morphine sulfate ER capsule (generic Avinza)
❑ Morphine sulfate ER capsule (generic Kadian)
❑ Morphine sulfate ER tablet
❑ Oxycodone ER
❑ Oxycontin
❑ Oxymorphone ER
❑ Xtampza ER

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.*

Nucynta® ER 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.