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

Tramadol Products 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:

- ❑ Acute pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate [**Ultracet (tramadol-acetaminophen)** only]
- ❑ Moderate to moderately severe chronic pain requiring daily, around the clock, long term opioid treatment and for which alternative treatment options are inadequate [**Conzip, tramadol extended-release (ER) capsule, tramadol ER tablet** only]
- ❑ Pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate [**Ultram (tramadol)** only]
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

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

- ❑ Acetaminophen-codeine
- ❑ Butorphanol
- ❑ Synalgos-DC
- ❑ Tramadol ER capsule
- ❑ Tramadol ER tablet (generic Ryzolt)
- ❑ Tramadol ER tablet (generic Ultram ER)
- ❑ Tramadol immediate-release (IR)
- ❑ Tramadol-acetaminophen
- ❑ Trezix
- ❑ Other tramadol containing product (e.g., Ultram, Ultracet). Please specify: _____
- ❑ Other long-acting opioid [e.g., MS Contin (morphine controlled-release), Oxycontin (oxycodone ER)]. Please specify: _____

Quantity limit requests:

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 OptumRx Pharmacy Helpdesk at (800) 788-7871 at the time they are filling the prescription for a one-time override.***

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**

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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.*

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.