



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit [go.covermymeds.com/OptumRx](http://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

## Xtampza<sup>®</sup> ER Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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 <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information <small>(required)</small>
<p><b>Select the diagnosis below:</b></p> <p><input type="checkbox"/> Management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which other treatment options (e.g., non-opioid analgesics or immediate-release opioids) are inadequate</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>

<p><b>Select the medications the patient has a failure, contraindication, or intolerance to:</b></p> <p><input type="checkbox"/> Embeda <span style="margin-left: 200px;"><input type="checkbox"/> Nucynta ER</span></p> <p><input type="checkbox"/> Hysingla ER <span style="margin-left: 180px;"><input type="checkbox"/> Oxycodone ER</span></p> <p><input type="checkbox"/> Morphabond ER <span style="margin-left: 200px;"><input type="checkbox"/> Oxycontin</span></p>	
---	--

<p><b>Quantity limit requests:</b></p> <p>What is the quantity requested per DAY? _____</p> <p>Does the patient's diagnosis include malignant (cancer) pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the medication being used to treat postoperative pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;"><b>If yes, answer the following:</b></p> <p style="padding-left: 40px;">Is the medication being prescribed for pain related to a dental procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 40px;">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</p> <p>Was the medication prescribed by a pain specialist or by pain management consultation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Select all of the following that have been maintained and documented in chart notes*:</b></p> <p><input type="checkbox"/> A description of the nature and intensity of the pain</p> <p><input type="checkbox"/> An appropriate patient medical history and physical examination</p> <p><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)</p> <p><input type="checkbox"/> Appropriate dose escalation</p> <p><input type="checkbox"/> Ongoing, periodic review of the course of opioid therapy</p> <p><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</p> <p><b>Chart documentation:</b></p> <p>Will chart documentation be submitted to OptumRx<sup>®</sup> with this form, confirming the above information? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>*Please note: Chart documentation of the above is required to be submitted for quantity limit requests for this drug.</i></p>
--

**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.

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: XtampzaER\_CMS\_2019Mar-W