

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 <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NP#:		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"/> Malignant (cancer) pain <input type="checkbox"/> Neuropathic pain associated with diabetic peripheral neuropathy <input type="checkbox"/> Non-malignant pain. Document diagnosis: _____ <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Non-malignant pain: Has the patient had a trial and failure to <u>three (3) opioids</u> in attempts to treat the patient's intractable pain? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please document the date, drug, dose and frequency below:					
Date		Drug		Dose & Frequency	
Has the patient had a trial and failure to <u>additional pain therapies</u> (e.g., anti-seizures medications, antidepressants, TENS unit, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , please document the date, therapy, dose and frequency below:					
Date		Therapy		Dose & Frequency	
Has the provider checked information on this patient in the state's Prescription Monitoring Program (PMP) database within the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes to the above, document date PMP database was checked: _____					

Nucynta® ER Prior Authorization Request Form (Page 2 of 2)

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

Neuropathic pain associated with diabetic peripheral neuropathy :

Has the patient had a trial and failure to three (3) therapies used to treat the patient's condition (e.g., anticonvulsants, antidepressants)? Yes No

If **yes**, please document the date, drug, dose and frequency below:

Date	Drug	Dose & Frequency

Has the patient had a trial and failure to additional pain therapies (e.g., anti-seizures medications, antidepressants, TENS unit, etc.)? Yes No

If **yes**, please document the date, therapy, dose and frequency below:

Date	Therapy	Dose & Frequency

Has the provider checked information on this patient in the state's Prescription Monitoring Program (PMP) database within the last 90 days? Yes No

If **yes** to the above, document date PMP database was checked: _____

Quantity limit requests:

What is the quantity requested per DAY? _____

Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed*): _____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? Yes No

If **Yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

*** Please note: Chart documentation of the above is required to be submitted along with this fax*

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: _____ **Date:** _____

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.
 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: NucyntaER_Optima_2018Jan-W