ANALGESICS, NON-OPIOID BARBITURATE COMBINATIONS

PRIOR AUTHORIZATION FORM (*form effective 1/6/2025*)

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines and Quantity Limits/Daily Dose Limits are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html

☐New request ☐Renewal request	Total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:		Strength:
Dosage form (tablet, capsule, etc):	Quantity: _____ per _____ days	Refills:
Directions:		
Diagnosis:		Dx code (*required*):

Complete the sections below that are applicable to the member and this request and SUBMIT DOCUMENTATION for each item.

1. **For ALL requests:**
   - ☐Is not taking primidone or any other drug(s) containing a barbiturate (e.g., phenobarbital)
   - ☐Will not take the requested drug on more than 3 days per month
   - ☐Has a diagnosis of headache based on the current International Headache Society Classification of Headache Disorders
   - ☐Has a history of trial and failure of or a contraindication or an intolerance to standard abortive drugs for the treatment of headache based on headache classification:
     - ☐acetaminophen
     - ☐analgesic/caffeine combinations (e.g., Excedrin)
     - ☐aspirin
     - ☐NSAIDs:_____
     - ☐other: _____
2. **For a member 65 YEARS OF AGE OR OLDER:**
   - ☐The benefits of the requested drug outweigh the increased risks based on the prescriber's assessment
   - ☐Was counseled by the prescriber regarding the potential increased risks of the requested drug

pa health & wellness

3. **For the treatment of CHRONIC DAILY HEADACHE (presence of headache on 15 or more days per month for at least 3 months):**
   - ☐ Secondary causes of headache ruled out based on a physical exam
   - ☐ Secondary causes of headache ruled out based on a complete neurological exam
   - ☐ Was evaluated for the overuse of abortive drugs for the treatment of headache, including acetaminophen, butalbital, caffeine, NSAIDs, opioids, and triptans
   - ☐ Was counseled regarding behavioral modifications, such as cessation of caffeine and tobacco use, improved sleep hygiene, dietary changes, and regular mealtimes
   - ☐ Is currently taking preventive drug therapy based on headache classification or has a contraindication or an intolerance to preventive drug therapies:
     - ☐ tricyclic antidepressants (e.g., amitriptyline, nortriptyline, protriptyline):_____
     - ☐ other antidepressants (e.g., mirtazapine, SNRIs [e.g., venlafaxine]):_____
     - ☐ anticonvulsants (e.g., gabapentin, topiramate):_____
     - ☐ tizanidine (Zanaflex)
     - ☐ other: _____
   - ☐ Was counseled regarding the potential adverse effects of the requested drug, including the risk of medication overuse headache, misuse, abuse, and addiction
   - ☐ Has a history of substance use disorder AND:
     - ☐ Has results of a recent urine drug screen testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, and tramadol) that is consistent with prescribed controlled substances

4. **For a NON-PREFERRED Analgesic, Non-Opioid Barbiturate Combination:**
   - ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Analgesics, Non-Opioid Barbiturate Combinations that are approved or medically accepted for treatment of the member's diagnosis (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.):*_____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)