ANALGESICS, OPIOID SHORT-ACTING 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 for **Analgesics, Opioid Short-Acting** 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	# of pages: _____	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:	Formulation (capsule, tablet, etc.):
Directions:		Weight (if <21 years of age):
Quantity per fill: _____ to last _____ days		Requested duration:
Diagnosis *(submit documentation)*:		Dx code (*required*):

- **Pennsylvania law requires prescribers to query the PA PDMP each time a patient is prescribed an opioid drug product or benzodiazepine.**
- **Naloxone is available at Pennsylvania pharmacies via standing order from the Secretary of the Department of Health. Pennsylvania Medical Assistance beneficiaries may obtain naloxone free-of-charge through their prescription drug benefit.**

Complete all sections that apply to the member and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. **For a transmucosal fentanyl product:**
   - ☐Has a diagnosis of cancer
   - ☐Is opioid-tolerant (opioid-tolerant is defined as taking at least morphine 60 mg/day, transdermal fentanyl 25 mcg/hour, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for one week or longer)
   - ☐Is prescribed transmucosal fentanyl by a specialist certified in pain medicine, oncology, or hospice and palliative medicine
   - ☐Has a contraindication to the preferred Analgesics, Opioid Short-Acting *(See the Preferred Drug List for the list of preferred Analgesics, Opioid Short-Acting at: https://papdl.com/preferred-drug-list)*:_____
2. **For nasal butorphanol:**
   - ☐Is not opioid-tolerant (opioid-tolerant is defined as taking at least morphine 60 mg/day, transdermal fentanyl 25 mcg/hour, oxycodone 30

mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for one week or longer)

☐ Is being treated for **migraine** and**:**

- ☐ Is prescribed nasal butorphanol by a neurologist or headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties
- ☐ Tried and failed or has a contraindication or an intolerance to the following abortive medications:
  - ☐ acetaminophen ☐ triptans
  - ☐ NSAIDs ☐ dihydroergotamine
- ☐ Tried and failed or has a contraindication or an intolerance to the following preventive medications:
  - ☐ anticonvulsants ☐ botulinum toxins ☐ calcium channel blockers ☐ tricyclic antidepressants
  - ☐ beta blockers ☐ CGRP inhibitors ☐ SNRIs

☐ Is being treated for **non-migraine pain** and**:**

- ☐ Is prescribed nasal butorphanol by a specialist certified in neurology, pain medicine, oncology, or hospice and palliative care medicine
- ☐ Tried and failed or has a contraindication or intolerance to at least 3 unrelated (i.e., different opioid ingredient) preferred Analgesics, Opioid Short-Acting *(See the Preferred Drug List for the list of preferred Analgesics, Opioid Short-Acting at: https://papdl.com/preferred-drug-list)*:_____

3. **For a non-preferred Analgesic, Opioid Short-Acting** *(See the Preferred Drug List for the list of preferred and non-preferred Analgesics, Opioid Short-Acting at: https://papdl.com/preferred-drug-list)***:**

☐ Tried and failed or has a contraindication or an intolerance to the preferred Analgesics, Opioid Short-Acting:_____

4. **For a member with a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder (OUD) OR Vivitrol (naltrexone extended-release suspension for injection):**

☐ Both prescriptions are prescribed by the same prescriber

☐ Prescriptions are prescribed by different prescribers and all prescribers are aware of the other prescription(s)

☐ Not applicable – member is not taking a buprenorphine agent indicated for the treatment of OUD or Vivitrol

5. **For all Analgesics, Opioid Short-Acting:**

☐ Has a diagnosis of active cancer, sickle cell with crisis, or neonatal abstinence syndrome

☐ Is receiving palliative care or hospice services

☐ Is receiving treatment post-operatively or following a traumatic injury

☐ Has documentation of pain that is all of the following:

- ☐ Caused by a medical condition
- ☐ Moderate to severe
- ☐ Not migraine in type *(does NOT apply to nasal butorphanol)*

☐ Tried and failed or has a contraindication or an intolerance to non-opioid analgesics appropriate for the member's condition:

- ☐ acetaminophen
- ☐ duloxetine (e.g., Cymbalta, Drizalma):_____
- ☐ gabapentinoids (e.g., gabapentin, pregabalin [Lyrica]):_____
- ☐ NSAIDs (e.g., ibuprofen, naproxen, meloxicam, etc.):_____
- ☐ tricyclic antidepressants (e.g., amitriptyline, nortriptyline, etc.):_____
- ☐ other (specify): _____

☐ Was assessed for the potential risk of opioid misuse or opioid use disorder by the prescriber

6. **For a member with a concurrent prescription for a benzodiazepine:**

☐ The benzodiazepine is being tapered

☐ The opioid is being tapered

☐ Concomitant use of the benzodiazepine and opioid is medically necessary:_____

☐ Not applicable – member is not taking a benzodiazepine

7. **For a member who has received opioid treatment for the past 3 months:**

☐ Has results of a recent urine drug screen (UDS) testing for licit and illicit drugs with the potential for abuse, including specific testing for oxycodone, fentanyl, buprenorphine, and tramadol, that is consistent with prescribed controlled substances

pa health & wellness

RENEWAL requests

1. **For <u>all</u> Analgesics, Opioid-Short Acting:**
   - ☐ Has a diagnosis of active cancer, sickle cell with crisis, or neonatal abstinence syndrome
   - ☐ Is receiving palliative care or hospice services
   - ☐ Experienced an improvement in pain control and/or level of functioning while on the requested medication
   - ☐ Has results of a recent urine drug screen (UDS) testing for licit and illicit drugs with the potential for abuse, including specific testing for oxycodone, fentanyl, buprenorphine, and tramadol, at least every 12 months that is consistent with prescribed controlled substances
2. **For a member with a concurrent prescription for a benzodiazepine:**
   - ☐ The benzodiazepine is being tapered
   - ☐ The opioid is being tapered
   - ☐ Concomitant use of the benzodiazepine and opioid is medically necessary:_____
   - ☐ Not applicable – member is not taking a benzodiazepine

PLEASE <u>FAX</u> COMPLETED FORM WITH <u>REQUIRED CLINICAL DOCUMENTATION</u> 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.)