Prior Authorization Request Form for Short-Acting Opioid Analgesics

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/

☐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.

Quantity Limit:
☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.pahealthwellness.com/providers/pharmacy.html under PHW Quantity Limit List), please provide supporting information:_____

Therapeutic Duplication:
If concurrently prescribed a therapeutic duplicate (i.e. another short-acting opioid analgesic or dose different from the agent being requested):
☐ is being transitioned from one short-acting opioid analgesic to another with the intent of discontinuing one of the medications
☐ has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines. Supporting evidence:_____

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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

     Medications tried and failed or has a contraindication or an intolerance to:_____
   - ☐ 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
     - ☐ Not migraine in type
     - ☐ Moderate to severe
   - ☐ 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 <u>the past 3 months</u>:

☐ 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

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 <u>oxycodone, fentanyl, buprenorphine, and tramadol</u>**, 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

ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION

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.)