pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

SHORT-ACTING OPIOID ANALGESICS PRIOR AUTHORIZATION FORM *(form effective 7/23/18)*

Prior authorization & quantity limit guidelines are on the Pharmacy Services website: http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # pages: _____	Prescriber name:	
Name/phone of office contact:		Specialty:	
LTC facility contact/phone:		NPI:	State license:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug:	Strength:	Quantity per fill: _____ to last ____ days
Directions:		Duration: _____ days / 1 mo / 2 mos / 3 mos
Weight (if <21 yrs): _____	Diagnosis (*submit documentation*):	Diagnosis code (*required*):

1. Did the prescriber or prescriber's delegate search the PDMP to review the beneficiary's controlled substance prescription history before issuing this prescription for the requested agent?
   ☐Yes ☐No *Submit documentation.*
2. Is the beneficiary taking a benzodiazepine? ***Submit beneficiary's current medication list.***
   ☐Yes – list: _____ ☐No
3. ***Initial requests for all non-preferred medications:*** Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the following preferred short-acting opioid analgesics? *Check all that apply.*
   ☐APAP/codeine tablet or elixir ☐morphine IR tablet ☐oxycodone/APAP tablet
   ☐hydrocodone/APAP tablet ☐morphine solution or concentrate ☐tramadol IR tablet
   ☐hydrocodone/ibuprofen tablet ☐oxycodone IR tablet
   ☐Yes ☐No *Submit documentation of trial & failure, contraindications, or intolerances.*
4. What is the anticipated duration of therapy with opioid analgesics?
   Specify duration: _____ *Submit documentation.*
5. Is the beneficiary being treated for active cancer, sickle cell with crisis, or neonatal abstinence syndrome OR receiving hospice or palliative care services?
   ☐Yes – *Submit documentation and* ***send to DHS.***
   ☐No – ***Continue to the next question.***
6. Check all of the following that apply to the beneficiary. ***Submit detailed medical record documentation for EACH item.***

INITIAL requests:
- ☐has documentation of a complete physical exam, including diagnostic testing/imaging results, and pain assessment (cause, severity, location, etc)
- ☐has tried or cannot try non-drug pain management modalities (eg, behavioral, cognitive, physical, and/or supportive therapies)
- ☐has tried or cannot try non-opioid drugs for the treatment of pain – check drugs tried: ☐acetaminophen ☐NSAIDs ☐other: _____
- ☐the requested opioid medication will be used in combination with tolerated non-drug therapies and non-opioid medications
- ☐was assessed for the potential risk of misuse, abuse, and addiction based on family and social history obtained by prescriber
- ☐was counseled regarding potential side effects of opioids including risk of misuse, abuse, addiction (if <21 yo, parent/guardian may be counseled)
- ☐was assessed for recent (within the past 60 days) opioid use
- ☐was evaluated for risk factors for opioid-related harm
  - ☐*if identified to be at high risk for opioid-related harm,* the prescriber considered prescribing naloxone
- ☐has a recent UDS testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, tramadol, and carisoprodol)

RENEWAL requests:
- ☐experienced an improvement in pain control and level of functioning while on the requested agent
- ☐the requested opioid medication will be used in combination with tolerated non-drug therapies and non-opioid medications
- ☐is being monitored by the prescriber for adverse events and warning signs of serious problems, such as overdose and opioid use disorder
- ☐was evaluated for risk factors for opioid-related harm
  - ☐*if identified to be at high risk for opioid-related harm,* the prescriber considered prescribing naloxone
- ☐has a recent UDS testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, tramadol, and carisoprodol)

7. **For requests for nasal butorphanol (Stadol),** check all of the following that apply to the beneficiary. ***Submit documentation for EACH item.***
   - ☐the beneficiary is opioid-tolerant (names and dosages of current opioid regimen)
   - ☐*if being treated for migraine*, has a history of trial & failure of or contraindication or intolerance to abortive (triptans) & preventive medications

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: