

LONG-ACTING NARCOTICS – ADULTS (Recipients ≥ 21 years)

PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for these agents, refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Analgesics, Narcotic Long Acting: <http://www.dpw.state.pa.us/publications/bulletinsearch/index.htm>. These agents are also subject to quantity limits – if the requested quantity exceeds the limit, please submit supporting chart documentation (list of limits accessible at: <http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information

For Additional Information: Coordinator Name: _____ PA#: _____

Number of Pages in this Request: _____ Office Contact Name: _____ & Phone: (____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____

NPI#: _____ OR MA Provider ID#: _____ State License#: _____

Prescriber Address: _____ Suite #: _____

City/State/Zip: _____ Phone: (____) _____ Fax: (____) _____

MEDICAL INFORMATION

Preferred Agents: fentanyl patch Kadian (morphine ER) methadone tablet/oral solution morphine ER tablet

Non-Preferred Agents: AVINza Butrans patch ConZip Duragesic Exalgo MS Contin

morphine ER capsule Nucynta ER Opana ER Oxycontin oxymorphone ER tramadol ER Ultram ER

Zohydro ER

Strength: _____ **Directions:** _____ **Days' Supply:** _____

Duration of Therapy: _____ **Diagnosis:** _____ **Diagnosis Code:** _____ (required)

All Requests

1. Reason for Recipient's pain: _____ – submit a complete pain assessment (location, severity, duration, etc)

2. Check all that apply to the Recipient and submit documentation:

Tried & failed (or has a contraindication or intolerance to) non-pharmacologic pain management modalities

Tried & failed (or has a contraindication or intolerance to) non-opioid analgesics: acetaminophen NSAID Other: _____

Had a trial of short-acting narcotics

Is opioid-tolerant

Is pregnant or breastfeeding

Has been educated on the potential side effects of using narcotic analgesics, including the risk for misuse, abuse and addiction

3. Does the Recipient have a history of substance use disorder (prescription drug, illicit drug or alcohol dependence or abuse)?

Yes – submit documentation and complete question (3a) No

3a. Does the Recipient have a recent urine drug screen (UDS)? The screen should include benzodiazepines, opiates (including fentanyl & oxycodone) and illicit drugs: Yes – submit UDS results No

Non-Preferred Requests: Has the Recipient tried and failed (or have a contraindication or intolerance to) any of the preferred Long Acting Narcotic Analgesics (listed above)? Yes – submit documentation No

Renewal Requests

1. Has the Recipient experienced an improvement in pain control and level of functioning? Yes – submit documentation No

2. Does the Recipient have a history of substance use disorder (prescription drug, illicit drug or alcohol dependence or abuse)?

Yes – submit documentation and complete question (2a) No

2a. Does the Recipient have a recent urine drug screen (UDS)? The screen should include benzodiazepines, opiates (including fentanyl & oxycodone) and illicit drugs: Yes – submit UDS results No

PLEASE SEND COMPLETED FORM WITH CLINICAL INFORMATION TO DPW – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____

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