

SHORT-ACTING NARCOTICS – ADULTS

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 Short-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

NOTE: This form is for requests for Non-Preferred Short-Acting Narcotic Analgesics for Recipients ≥ 21 years (i.e., adults). For requests for Recipients < 21 years, please use the “Narcotics in Recipients < 21 Years” form.

Medication Requested: _____ Strength: _____

Directions: _____ Quantity: _____ Refills: _____

Diagnosis (submit documentation): _____ Diagnosis Code: _____ (Required)

All Requests:

1. Which of the following preferred short-acting products has the Recipient tried and failed? Related products are grouped together (APAP = acetaminophen; IR = immediate-release) – check all that apply and submit documentation:

Codeine: APAP/codeine

Hydrocodone: hydrocodone/APAP hydrocodone/ibuprofen

Hydromorphone: hydromorphone (tablets only – requires Prior Authorization)

Morphine: morphine IR

Oxycodone: oxycodone IR Endocet, Roxicet or oxycodone/APAP

Tramadol: tramadol

2. Does the Recipient have contraindications or intolerances to any of the preferred agents listed in question (1)?

Yes – submit documentation No

Requests for Oral Fentanyl Products (e.g., Abstral, Actiq, Fentora, Onsolis):

1. Is the Recipient opioid-tolerant? Yes – submit documentation No

Requests for Nasal Butorphanol: Check all that apply to the Recipient and submit documentation

Recipient is NOT opioid-tolerant

Requests for Migraine Treatment:

Recipient tried & failed (or has a contraindication or intolerance to) triptan medications to relieve migraine symptoms

Recipient tried & failed (or has a contraindication or intolerance to) an agent in the following medication classes used for prevention of migraines: Anticonvulsants Beta Blockers Calcium Channel Blockers NSAIDs TCAs SSRIs

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

Prescriber Signature: _____ **Date:** _____

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