pennsylvania
DEPARTMENT OF HUMAN SERVICES

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

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

Prior authorization guidelines are accessible on the Department's Pharmacy Services website at 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 or LTC facility contact:		Specialty:	NPI:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

Medication Requested (*Names in parentheses are the brand name equivalents for reference purposes.*)

Preferred Agents

☐ fentanyl patch 12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg (*Duragesic*)
☐ Embeda ER capsule
☐ morphine ER tablet (*MS Contin*)

Non-Preferred Agents

☐ Arymo ER tablet
☐ Belbuca film
☐ buprenorphine patch (*Butrans*)
☐ Butrans patch
☐ Dolophine tablet
☐ Duragesic patch
☐ Exalgo tablet
☐ fentanyl patch (37.5, 62.5, 87.5 mcg)
☐ hydromorphone ER tablet (*Exalgo*)
☐ Hysingla ER tablet
☐ Kadian ER capsule
☐ methadone tablet
☐ methadone solution
☐ Morphabond ER tablet
☐ morphine ER capsule (*Avinza*)
☐ morphine ER capsule (*Kadian*)
☐ MS Contin tablet
☐ Nucynta ER tablet
☐ Opana ER tablet
☐ oxycodone ER tablet (*OxyContin*)
☐ OxyContin tablet
☐ oxymorphone ER tablet (*Opana*)
☐ tramadol ER capsule (*ConZip*)
☐ tramadol ER tablet (*Ultram ER*)
☐ tramadol ER biphasic tablet (*Ryzolt*)
☐ Xtampza ER capsule
☐ Zohydro ER capsule
☐ ________________________

Strength:	Directions:	Qty per fill: ______ to last ____ days	Duration: _____ days / 1 mo / 2 mos / 3 mos
Weight (if <21 yrs): _________ lbs / kg	Diagnosis (*submit documentation*):		Dx code (*required*):

Question	Response	
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. ***For initial requests for a NON-PREFERRED agent,*** does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred Long-Acting Opioids listed above?	☐ Yes ☐ No	*Submit documentation of medications tried and treatment outcomes, including intolerances or contraindications.*
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 recent (within the past 60 days) opioid use
☐ has documentation of a trial of short-acting opioids
☐ is opioid-tolerant
☐ 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 evaluated for risk factors for opioid-related harm ☐ *if identified to be at high risk*, 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*, 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)

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

Prescriber Signature:	Date:

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