

ANALGESICS, OPIOID LONG-ACTING PRIOR AUTHORIZATION FORM (form effective 01/05/2021)

Prior authorization guidelines for Analgesics, Opioid Long-Acting and Quantity Limits/Daily Dose Limits are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.

Drug requested:	Strength:	Formulation (capsule, tablet, etc.):
Directions:		Weight (if <21 years of age):
Quantity per fill: _____ to last _____ days		Requested duration:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):
<p><i>For initial requests for a NON-PREFERRED medication, does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred Analgesics, Opioid Long-Acting? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.</i></p>		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of medications tried and treatment outcomes, including intolerances or contraindications.</i>
<p>Is the beneficiary being treated for active cancer, sickle cell with crisis, or neonatal abstinence syndrome OR receiving hospice or palliative care services?</p>		<input type="checkbox"/> Yes – <i>Submit documentation and send to DHS.</i> <input type="checkbox"/> No – <i>Continue with form.</i>
<p>What is the anticipated duration of therapy with opioid analgesics?</p>		<p>Duration: _____ <i>Submit documentation.</i></p>
<p>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?</p>		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
<p>Is the beneficiary taking a benzodiazepine? <i>Submit beneficiary's current medication list.</i></p>		<input type="checkbox"/> Yes – specify: _____ <input type="checkbox"/> No

INITIAL requests

Complete the sections below that are applicable to the beneficiary and this request and **SUBMIT DOCUMENTATION** for each item.

- 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:
 - acetaminophen
 - Cymbalta (duloxetine)
 - gabapentin
 - NSAIDs (e.g., ibuprofen, naproxen, meloxicam, etc.)
 - Lyrica (pregabalin)
 - tricyclic antidepressants (e.g., amitriptyline, nortriptyline, etc.)
 - other (specify): _____

- Will use the requested opioid in combination with tolerated non-drug therapies and non-opioid drugs
- Has documentation of a trial of short-acting opioids
- For new starts of a long-acting opioid, is opioid-tolerant
- Was assessed for the potential risk of misuse, abuse, or addiction based on family and social history obtained by the prescriber
- Was counseled about the potential side effects of opioids, including the risk for misuse, abuse, and addiction OR, if under 21 years of age, a parent or guardian was counseled about these risks
- Was evaluated for risk factors for opioid-related harm
 - Determined to be at high-risk for opioid-related harm
 - The prescriber considered prescribing naloxone for the beneficiary
- Was assessed for recent use of opioids (within the past 60 days)
- 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, and tramadol

RENEWAL requests

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

- Experienced an improvement in pain control and/or level of functioning while on the requested medication
- Will use the requested opioid in combination with tolerated non-drug therapies and non-opioid drugs
- Was recently evaluated 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
 - Determined to be at high-risk for opioid-related harm
 - The prescriber considered prescribing naloxone for the beneficiary
- 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, and tramadol

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

Prescriber Signature:

Date:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.