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

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

Prior authorization guidelines for **Analgesics, Opioid Short-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.

☐New request ☐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 *(submit documentation)*:		Dx code (*required*):
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 Short-Acting? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*		☐Yes ☐No *Submit documentation of medications tried and treatment outcomes, including intolerances or contraindications.*
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 with form.***
What is the anticipated duration of therapy with opioid analgesics?		Duration: _____ *Submit documentation.*
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.*
Is the beneficiary taking a benzodiazepine? ***Submit beneficiary's current medication list.***		☐Yes – specify: _____ ☐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/imagining 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): _____

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- ☐ Will use the requested opioid in combination with tolerated non-drug therapies and non-opioid drugs
- ☐ 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 guarding 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
- ☐ The requested medication is a **transmucosal fentanyl product**
  - ☐ Has a diagnosis of cancer
  - ☐ Is opioid-tolerant
  - ☐ Is prescribed transmucosal fentanyl by a specialist certified in pain medicine, oncology, or hospice and palliative medicine
  - ☐ Has a contraindication to the preferred Analgesics, Opioid Short-Acting *(refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class)*
- ☐ The requested medication is a **nasal butorphanol product**
  - ☐ Is not opioid-tolerant
  - ☐ Is being treated for **migraine**
    - ☐ Is prescribed nasal butorphanol by a neurologist or headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties
    - ☐ Tried and failed or has a contraindication or intolerance to the following abortive medications:
      - ☐ Acetaminophen ☐ Triptans
      - ☐ NSAIDs ☐ Dihydroergotamine
    - ☐ Tried and failed or has a contraindication or intolerance to the following preventive medications:
      - ☐ Anticonvulsants ☐ Botulinum toxins ☐ Calcium channel blockers ☐ tricyclic antidepressants
      - ☐ Beta blockers ☐ CGRP inhibitors ☐ SNRIs
  - ☐ Is being treated for **non-migraine pain**
    - ☐ Is prescribed nasal butorphanol by a specialist certified in neurology, pain medicine, oncology, or hospice and palliative care medicine
    - ☐ Tried and failed or has a contraindication or intolerance to at least 3 unrelated (ie, different opioid ingredient) preferred Analgesics, Opioid Short-Acting

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: