

## ANALGESICS, OPIOID LONG-ACTING PRIOR AUTHORIZATION FORM (form effective 1/1/20)

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	Total # pages: _____	Prescriber name:
Name of office or LTC facility contact:		Specialty:	NPI:
Phone number of office/LTC contact:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

### CLINICAL INFORMATION

Drug requested:	Strength:	
Directions:		
Quantity per fill: _____ to last ____ days	Requested duration: _____ days / 1 mo / 2 mos / 3 mos	Weight (if <21 yrs): _____ lbs / kg
Diagnosis ( <u>submit documentation</u> ):		Dx code ( <u>required</u> ):
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?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
Is the beneficiary taking a benzodiazepine? <b><u>Submit beneficiary's current medication list.</u></b>		<input type="checkbox"/> Yes – list: _____ <input type="checkbox"/> No
<b>For initial requests for a <u>NON-PREFERRED</u> agent</b> , does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred Analgesics, Opioid Long-Acting? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred medications in this class.		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of medications tried and treatment outcomes, including intolerances or contraindications.</i>
What is the anticipated duration of therapy with opioid analgesics?	Specify duration: _____ <i>Submit documentation.</i>	
Is the beneficiary being treated for active cancer, sickle cell with crisis, or neonatal abstinence syndrome OR receiving hospice or palliative care services?	<input type="checkbox"/> Yes – <i>Submit documentation and send to DHS.</i> <input type="checkbox"/> No – <b>Continue to the next question.</b>	
Check all of the following that apply to the beneficiary. <b><u>Submit detailed medical record documentation for EACH item.</u></b>		
<b>INITIAL requests:</b>		
<input type="checkbox"/> has documentation of a complete physical exam, including diagnostic testing/imaging results, and pain assessment (cause, severity, location, etc)		
<input type="checkbox"/> has tried or cannot try non-drug pain management modalities (eg, behavioral, cognitive, physical, and/or supportive therapies)		
<input type="checkbox"/> has tried or cannot try non-opioid drugs for the treatment of pain – check drugs tried: <input type="checkbox"/> acetaminophen <input type="checkbox"/> NSAIDs <input type="checkbox"/> other: _____		
<input type="checkbox"/> the requested opioid medication will be used in combination with tolerated non-drug therapies and non-opioid medications		
<input type="checkbox"/> was assessed for recent (within the past 60 days) opioid use		
<input type="checkbox"/> has documentation of a trial of short-acting opioids		
<input type="checkbox"/> is opioid-tolerant		
<input type="checkbox"/> was assessed for the potential risk of misuse, abuse, and addiction based on family and social history obtained by prescriber		
<input type="checkbox"/> was counseled regarding potential side effects of opioids including risk of misuse, abuse, addiction (if <21 yo, parent/guardian may be counseled)		
<input type="checkbox"/> was evaluated for risk factors for opioid-related harm <input type="checkbox"/> <i>if identified to be at high risk</i> , the prescriber considered prescribing naloxone		
<input type="checkbox"/> has a recent UDS testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, tramadol, and carisoprodol)		
<b>RENEWAL requests:</b>		
<input type="checkbox"/> experienced an improvement in pain control and level of functioning while on the requested agent		
<input type="checkbox"/> the requested opioid medication will be used in combination with tolerated non-drug therapies and non-opioid medications		
<input type="checkbox"/> is being monitored by the prescriber for adverse events and warning signs of serious problems, such as overdose and opioid use disorder		
<input type="checkbox"/> was evaluated for risk factors for opioid-related harm <input type="checkbox"/> <i>if identified to be at high risk</i> , the prescriber considered prescribing naloxone		
<input type="checkbox"/> 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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