

**ANALGESICS, OPIOID SHORT-ACTING PRIOR AUTHORIZATION FORM** (form effective 1/1/20)

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>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total # pages: _____	Prescriber name:	
Name/phone of office contact:		Specialty:	NPI:	
LTC facility contact/phone:		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):
Diagnosis ( <i>submit documentation</i> ):		Diagnosis code ( <i>required</i> ):
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 <i>Submit documentation.</i> <input type="checkbox"/> No
Is the beneficiary taking a benzodiazepine? <b><i>Submit beneficiary's current medication list.</i></b>		<input type="checkbox"/> Yes – list: _____ <input type="checkbox"/> No
<b><i>Initial requests for all non-preferred medications:</i></b> Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred Analgesics, Opioid Short-Acting? <i>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.</i>		<input type="checkbox"/> Yes <i>Submit documentation of trial &amp; failure, contraindications, or intolerances.</i> <input type="checkbox"/> No
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><i>Continue to the next question.</i></b>	
Check all of the following that apply to the beneficiary. <b><i>Submit detailed medical record documentation for EACH item.</i></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 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 assessed for recent (within the past 60 days) opioid use		
<input type="checkbox"/> was evaluated for risk factors for opioid-related harm		
<input type="checkbox"/> <i>if identified to be at high risk for opioid-related harm</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 for opioid-related harm</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>For requests for nasal butorphanol (Stadol), check all of the following that apply to the beneficiary. <i>Submit documentation for EACH item.</i></b>		
<input type="checkbox"/> the beneficiary is opioid-tolerant (names and dosages of current opioid regimen)		
<input type="checkbox"/> <i>if being treated for migraine</i> , has a history of trial & failure of or contraindication or intolerance to abortive (triptans) & preventive medications		

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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