



Prior Authorization Request Form for Short-Acting Opioid Analgesics

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at <https://www.covermymeds.com/main/prior-authorization-forms/>

<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:	
Member name:			City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength:	Formulation (capsule, tablet, etc.):
Directions:	Weight (if <21 years of age):	
Quantity per fill: _____ to last _____ days	Requested duration:	
Diagnosis (<u>submit documentation</u>):	DX code (<u>required</u>):	

- Pennsylvania law requires prescribers to query the **PA PDMP** each time a patient is prescribed an opioid drug product or benzodiazepine.
- Naloxone is available at Pennsylvania pharmacies via standing order from the Secretary of the Department of Health. Pennsylvania Medical Assistance beneficiaries may obtain naloxone **free-of-charge** through their prescription drug benefit.

Complete all sections that apply to the member and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

1. For a transmucosal fentanyl product:

- ☐ Has a diagnosis of cancer
- ☐ Is opioid-tolerant (opioid-tolerant is defined as taking at least morphine 60 mg/day, transdermal fentanyl 25 mcg/hour, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for one week or longer)
- ☐ 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 (See the Preferred Drug List for the list of preferred Analgesics, Opioid Short-Acting at: <https://papdl.com/preferred-drug-list>)

2. For nasal butorphanol:

- ☐ Is not opioid-tolerant (opioid-tolerant is defined as taking at least morphine 60 mg/day, transdermal fentanyl 25 mcg/hour, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for one week or longer)
- ☐ Is being treated for **migraine** and:
- ☐ 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 an intolerance to the following abortive medications:
- ☐ acetaminophen: _____ ☐ triptans: _____
- ☐ NSAIDs: _____ ☐ dihydroergotamine: _____
- ☐ Tried and failed or has a contraindication or an intolerance to the following preventive medications:
- ☐ anticonvulsants ☐ botulinum toxins ☐ calcium channel blockers ☐ tricyclic antidepressants
- ☐ beta blockers ☐ CGRP inhibitors ☐ SNRIs

Medications tried and failed or has a contraindication or an intolerance to: _____

- ☐ Is being treated for **non-migraine pain** and:
- ☐ 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 (i.e., different opioid ingredient) preferred Analgesics, Opioid Short-Acting (See the Preferred Drug List for the list of preferred Analgesics, Opioid Short-Acting at: <https://papdl.com/preferred-drug-list>)

3. For a non-preferred Analgesic, Opioid Short-Acting (See the Preferred Drug List for the list of preferred and non-preferred Analgesics, Opioid Short-Acting at: <https://papdl.com/preferred-drug-list>):

- ☐ Tried and failed or has a contraindication or an intolerance to the preferred Analgesics, Opioid Short-Acting: _____

4. For a member with a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder (OUD) OR Vivitrol (naltrexone extended-release suspension for injection):

- ☐ Both prescriptions are prescribed by the same prescriber
- ☐ Prescriptions are prescribed by different prescribers and all prescribers are aware of the other prescription(s)
- ☐ Not applicable – member is not taking a buprenorphine agent indicated for the treatment of OUD or Vivitrol

5. For all Analgesics, Opioid Short-Acting:

- ☐ Has a diagnosis of active cancer, sickle cell with crisis, or neonatal abstinence syndrome → **submit documentation**
- ☐ Is receiving palliative care or hospice services → **submit documentation**
- ☐ Is receiving treatment post-operatively or following a traumatic injury → **submit documentation**
- ☐ Has documentation of pain that is all of the following:

- ☐ Caused by a medical condition
- ☐ Not migraine in type
- ☐ Moderate to severe

- ☐ Tried and failed or has a contraindication or an intolerance to non-opioid analgesics appropriate for the member's condition:

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

- ☐ Was assessed for the potential risk of opioid misuse or opioid use disorder by the prescriber

6. For a member with a concurrent prescription for a benzodiazepine:

- ☐ The benzodiazepine is being tapered
- ☐ The opioid is being tapered
- ☐ Concomitant use of the benzodiazepine and opioid is medically necessary
- ☐ Not applicable – member is not taking a benzodiazepine

7. For a member who has received opioid treatment for the past 3 months:

- ☐ 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, buprenorphine, and tramadol**, that is consistent with prescribed controlled substances

RENEWAL requests

1. For all Analgesics, Opioid-Short Acting:

- ☐ Has a diagnosis of active cancer, sickle cell with crisis, or neonatal abstinence syndrome → **submit documentation**
- ☐ Is receiving palliative care or hospice services → **submit documentation**
- ☐ Experienced an improvement in pain control and/or level of functioning while on the requested medication
- ☐ 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, buprenorphine, and tramadol**, at least every 12 months that is consistent with prescribed controlled substances

2. For a member with a concurrent prescription for a benzodiazepine:

- ☐ The benzodiazepine is being tapered
- ☐ The opioid is being tapered
- ☐ Concomitant use of the benzodiazepine and opioid is medically necessary
- ☐ Not applicable – member is not taking a benzodiazepine

ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:

Date:

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)