Prior Authorization Request Form for Long-Acting Opioid Analgesics

FAX this completed form to (877) 386-4695

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

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:
Anticipated duration of opioid analgesic therapy:		Weight (if <21 yo):

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*	
Specify diagnosis & diagnosis code relevant to this request: *(NOTE: pain may not be migraine type, unless requesting nasal butorphanol)*	Dx/Dx Code: _____
Did the prescriber or prescriber's delegate search the PDMP to review the member's controlled substance prescription history before issuing this prescription for the requested agent?	☐ Yes ☐ No *Submit documentation.*
Is the member taking a benzodiazepine? *(NOTE: Concomitant benzodiazepine/opioid use will not be approved, unless the benzodiazepine or opioid is being tapered or concomitant use is determined to be medically necessary)*	☐ Yes ☐ No *Submit member's complete medication list. If concomitant benzodiazepine use, submit documentation of plan to taper/discontinue or provide justification of medical necessity.*
Does the member have a concomitant prescription for buprenorphine agent indicated for the treatment of opioid use disorder or naltrexone ER injectable (Vivitrol)?	☐ Yes ☐ No *Submit documentation.*
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Long-Acting Opioid Analgesics? *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 previous trials/failures, contraindications, and/or intolerances.*

Therapeutic Duplication:
If concurrently prescribed a therapeutic duplicate (i.e. a long-acting opioid analgesic different from the agent being requested):

- ☐ Is being transitioned to another long-acting opioid antagonist with the intent of discontinuing one of the medications
- ☐ Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines

Exceeds Quantity Limit:
If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx):

- ☐ Has documented severe pain (<21 years) or moderate to severe pain (≥21 years) by a pain assessment tool measurement:_____
- ☐ Prescribed by an appropriate specialist or in consultation specialist:_____
- ☐ Pain is inadequately controlled by current quantity limit
- ☐ Pain is inadequately controlled or has a contraindication or adverse reaction to alternative long-acting opioid analgesics
- ☐ Member's pain will not be more appropriately controlled by initiated or adjusting long-acting opioid analgesic

Is the member being treated for any of the following:	
☐ active cancer ☐ sickle cell with crisis ☐ neonatal abstinence syndrome ☐ receiving hospice or palliative care services	☐ Yes *If YES - Submit documentation.* ☐ No *If NO – continue to the following section(s)*

CHECK ALL THAT APPLY. ***SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.***

INITIAL REQUESTS:

- ☐ Documented pain assessment tool measurement (pain score):_____
- ☐ Member has tried or cannot try non-drug pain management modalities (e.g. behavioral, cognitive, physical, and/or supportive therapies):_____
- ☐ Member has tried or cannot try non-opioid drugs for the treatment of pain – specify medication, start and end date:
  - ☐ Acetaminophen:_____
  - ☐ Non-Steroidal Anti-Inflammatory Drugs (NSAIDs): _____
  - ☐ Gabapentinoid (e.g. gabapentin, pregabalin): _____
  - ☐ Duloxetine:_____
  - ☐ Tricyclic antidepressant (e.g. amitriptyline): _____
  - ☐ Other: _____
- ☐ Requested opioid medication will be used in combination with tolerated non-drug therapies and non-opioid medications:_____
- ☐ Member has documentation of a trial of short-acting opioids:_____
- ☐ Member is opioid-tolerant *(for adults, 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 equi-analgesic dose of another opioid for one week or longer):*_____
- ☐ Member was assessed for the potential risk of misuse, abuse, and addiction based on family and social history obtained by prescriber
- ☐ Member was counseled regarding potential side effects of opioids including risk of misuse, abuse, addiction (if <21 yo, parent/guardian may be counseled)
- ☐ Member was assessed for recent (within the past 60 days) opioid use
- ☐ Member was evaluated for risk factors for opioid-related harm
  - ☐ *If identified to be at high risk for opioid-related harm*, the prescriber considered prescribing naloxone
- ☐ Member has a recent UDS testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, and tramadol)

RENEWAL REQUESTS:

- ☐ Member has experienced an improvement in pain control and level of functioning while on the requested agent, as evidenced by:_____
- ☐ Requested opioid medication will be used in combination with tolerated non-drug therapies and non-opioid medications:_____

- ☐ Member is being monitored by the prescriber for adverse events and warning signs of serious problems, such as overdose and opioid use disorder
- ☐ Member was evaluated for risk factors for opioid-related harm
    - ☐ *If identified to be at high risk for opioid-related harm*, the prescriber considered prescribing naloxone
- ☐ Member has a recent urine drug screen testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, and tramadol) every 6 months for greater than 50MME per day and every 12 months for less than 50MME per day

IF REQUESTED LONG-ACTING OPIOID ANALGESIC IS BEING PRESCRIBED CONCURRENTLY WITH A BUPRENORPHINE AGENT OR AN EXTENDED-RELEASE INJECTABLE NALTREXONE SUSPENSION (VIVITROL) FOR THE TREATMENT OF OPIOID USE DISORDER:

- ☐ The prescriptions were prescribed by the same prescriber
- ☐ The prescriptions were prescribed by different prescribers
    - ☐ All prescribers are aware of the other prescriptions
- ☐ Has a need for therapy with an Analgesic, Opioid Long-Acting, and the other therapy will be suspended during the treatment for pain

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Envolve Pharmacy Solutions 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.)