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/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact 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	
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	*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	
Requests for all non-preferred medications: Does the member have a history of trial and failure of or 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	Medications Tried: [redacted]

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

- ☐ Is being transitioned to another short-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 short-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 ☐ 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 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 urine drug screen 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

REQUESTS FOR NASAL BUTORPHANOL (STADOL):

- ☐ Member is not opioid-tolerant *(submit complete list of medications)*
- ☐ ***For migraine***:
  - ☐ Has a history of trial & failure of or contraindication or intolerance to *all* abortive & preventive medications (medication, start date and end date):
    - ☐ Acetaminophen:_____
    - ☐ Non-Steroidal Anti-Inflammatory Drugs (NSAIDs):_____
    - ☐ Triptans:_____
    - ☐ Dihydroergotamine:_____
    - ☐ Anticonvulsant (e.g. topiramate, valproic acid, divalproex):_____
    - ☐ Beta-Blocker (e.g. metoprolol, propranolol, timolol):_____

- ☐ Botulinum toxin (for diagnosis of chronic migraine only):_____
- ☐ Calcitonin Gene-Related Peptide Inhibitors/Antagonist (e.g. Emgality, Aimovig, Nurtec):_____
- ☐ Calcium Channel Blocker (e.g. verapamil):_____
- ☐ Serotonin-Norepinephrine Reuptake Inhibitor (e.g. venlafaxine):_____
- ☐ Tricyclic Antidepressant (e.g. amitriptyline):_____

☐ Prescribed by a neurologist or headache specialist certified in headache medicine by the United Council for Neurologic Subspecialities:_____

☐ ***For pain***:

- ☐ Has a history of therapeutic failure, contraindication, or intolerance of at least 3 unrelated (i.e., different opioid ingredient) preferred short-acting opioid analgesics (single-entity or combination products) (medication, start date and end date):_____
- ☐ Prescribed by a specialist certified in neurology, pain medicine, oncology or hospice or palliative medicine:_____

REQUESTS FOR A TRANSMUCOSAL FENTANYL PRODUCT:

☐ Member has a diagnosis of cancer

☐ Member is opioid-tolerant *(submit complete list of medications)*

☐ Prescribed by a specialist certified in pain medicine, oncology, or hospice and palliative medicine by the American Board of Medical Specialties:_____

☐ Has a history of a contraindication to the preferred short-acting opioid analgesics:_____

REQUESTS FOR COMBINATION AGENT CONTAINING BARBITURATE:

☐ Refer to Analgesics, Non-Opioid Barbiturate Combinations policy at https://www.pahealthwellness.com/providers/resources/clinical-payment-policies.html for additional requirements for approval.

IF REQUESTED SHORT-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 an **acute** need for therapy with an Analgesic, Opioid Short-Acting, and the other therapy will be suspended during the treatment for acute 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:

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.)