Prior Authorization Request Form for Non-Opioid Barbiturate Analgesic Combinations

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:	Directions:	Qty. per Day:

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: 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
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Non-Opioid Barbiturate Combinations? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes Medications Tried:_____ _____ _____ ☐ No _____

- ☐ Member will not be taking Primidone or other medication(s) containing a barbiturate
- ☐ Member will not be taking the requested medication on more than 3 days per month
- ☐ Member has a diagnosis of headache based on the current International Headache Society Classification of Headache Disorder

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), please provide supporting information:_____

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

INITIAL REQUEST:

- ☐ Documented history of therapeutic failure, contraindication or intolerance of standard abortive medications (NSAIDs, acetaminophen, triptans, OTC analgesic/caffeine combination, etc.) (medication, start date and end date):_____

FOR MEMBER 65 YEARS OLD OR OLDER:

- ☐ Member received risk assessment by prescriber, benefits of requested medication outweigh the risk for the member
- ☐ Prescriber counseled regarding the potential increase risk of requested medication

FOR MEMBER WITH 15 OR MORE HEADACHE DAYS PER MONTH FOR AT LEAST LAST 3 MONTHS;

- ☐ Has documentation of results of physical examination and complete neurological exam to rule out secondary cause of headache
- ☐ Has documentation of an evaluation for the overuse of abortive medications, including but not limited to acetaminophen, NSAIDs, triptans, butalbital, caffeine and opioids
- ☐ Has documentation of prescriber counseling regarding behavioral modifications (cessation of caffeine and tobacco use, improved sleep hygiene, diet changes and regular mealtimes)
- ☐ Member is taking or has a contraindication or intolerance to a preventative drug therapy (such as beta-blocker, antidepressant, anticonvulsant) (medication, start date and end date):_____
- ☐ Prescriber has counseled the member regarding the potential adverse effects of requested medication, including the risk of medication overuse headache, misuse, abuse and addiction
- ☐ For members with a history of substance use disorder, has a results of recent urine drug screen testing for licit and illicit drugs with the potential of abuse (including oxycodone, fentanyl and tramadol) that is consistent with prescribed control substances

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.)