

LONG-ACTING OPIOID ANALGESICS PRIOR AUTHORIZATION FORM

(form effective 1/1/20)



Keystone First

PERFORMRxSM

Next Generation Pharmacy Benefits

Fax to PerformRxSM at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total # pages:	Name/phone of office or LTC facility contact:

PATIENT INFORMATION			
Patient name:	Patient ID#:	DOB:	
Street address:	Apt. #:	City/state/zip:	

PRESCRIBER INFORMATION			
Prescriber name:	Specialty:	NPI:	
Street address:	Suite #:	City/state/zip:	
Phone:	Fax:		

MEDICATION REQUESTED (Names in parentheses are the brand name equivalents for reference purposes.)

Preferred Agents			
<input type="checkbox"/> Butrans patch	<input type="checkbox"/> Embeda ER capsule	<input type="checkbox"/> Fentanyl patch 12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg (Duragesic)	<input type="checkbox"/> Morphine ER tablet (MS Contin)
Non-Preferred Agents			
<input type="checkbox"/> Arymo ER tablet	<input type="checkbox"/> hydromorphone ER tablet (Exalgo)	<input type="checkbox"/> morphine ER capsule (Kadian)	<input type="checkbox"/> tramadol ER capsule (ConZip)
<input type="checkbox"/> Belbuca film	<input type="checkbox"/> Hysingla ER tablet	<input type="checkbox"/> MS Contin tablet	<input type="checkbox"/> tramadol ER tablet (Ultram ER)
<input type="checkbox"/> buprenorphine patch (Butrans)	<input type="checkbox"/> Kadian ER capsule	<input type="checkbox"/> Nucynta ER tablet	<input type="checkbox"/> tramadol ER biphasic tablet (Ryzolt)
<input type="checkbox"/> Dolophine tablet	<input type="checkbox"/> methadone tablet	<input type="checkbox"/> Opana ER tablet	<input type="checkbox"/> Xtampza ER capsule
<input type="checkbox"/> Duragesic patch	<input type="checkbox"/> methadone solution	<input type="checkbox"/> oxycodone ER tablet (OxyContin)	<input type="checkbox"/> Zohydro ER capsule
<input type="checkbox"/> Exalgo tablet	<input type="checkbox"/> Morphabond ER tablet	<input type="checkbox"/> OxyContin tablet	
<input type="checkbox"/> fentanyl patch (37.5, 62.5, 87.5 mcg)	<input type="checkbox"/> morphine ER capsule (Avinza)	<input type="checkbox"/> oxymorphone ER tablet (Opana)	

Strength:	Qty per fill:	to last	days	Duration:	days / 1 mo / 2 mos / 3 mos
-----------	---------------	---------	------	-----------	-----------------------------

Directions:

Weight (if <21 yrs):	lbs / kg	Diagnosis (submit documentation):	Dx code (required):
----------------------	----------	-----------------------------------	---------------------

1. Did the prescriber or prescriber's delegate search the PDMP to review the patient'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	2. Is the patient taking a benzodiazepine? Submit patient's current medication list. <input type="checkbox"/> Yes - List and provide medical justification: <input type="checkbox"/> No
--	--

3. For initial requests for a **NON-PREFERRED** agent, does the patient have a history of trial and failure, contraindication, or intolerance to the preferred Long-Acting Opioids listed above? Yes No Check drugs tried: fentanyl patch Embeda ER capsule morphine ER tablet Butrans patch

4. What is the anticipated duration of therapy with opioid analgesics? Specify duration: *Submit documentation.*

5. Is the patient being treated for active cancer, sickle cell with crisis, or neonatal abstinence syndrome OR receiving hospice or palliative care services?
 Yes - Submit documentation. No - Continue to the next question.

6. Check all of the following that apply to the patient. **Submit detailed medical record documentation for EACH item.**

INITIAL requests:

- has documentation of a complete physical exam, including diagnostic testing/imaging results, and pain assessment (cause, severity, location, etc)
- has tried or cannot try non-drug pain management modalities (eg, behavioral, cognitive, physical, and/or supportive therapies)
- has tried or cannot try non-opioid drugs for the treatment of pain - check drugs tried: acetaminophen NSAIDs other: _____
- the requested opioid medication will be used in combination with tolerated non-drug therapies and non-opioid medications
- was assessed for recent (within the past 60 days) opioid use
- has documentation of a trial of short-acting opioids
- is opioid-tolerant
- was assessed for the potential risk of misuse, abuse, and addiction based on family and social history obtained by prescriber
- was counseled regarding potential side effects of opioids including risk of misuse, abuse, addiction (if <21 yo, parent/guardian may be counseled)
- was evaluated for risk factors for opioid-related harm if identified to be at high risk, the prescriber considered prescribing naloxone
- has a recent UDS testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, tramadol, and carisoprodol). Date of last UDS: _____

RENEWAL requests:

- experienced an improvement in pain control and level of functioning while on the requested agent
- the requested opioid medication will be used in combination with tolerated non-drug therapies and non-opioid medications
- is being monitored by the prescriber for adverse events and warning signs of serious problems, such as overdose and opioid use disorder
- was evaluated for risk factors for opioid-related harm if identified to be at high risk, the prescriber considered prescribing naloxone
- has a recent UDS testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, tramadol, and carisoprodol). Date of last UDS: _____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.