SHORT-ACTING OPIOID ANALGESICS PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

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

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ 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:	

CLINICAL INFORMATION

Drug:

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?
   ☐ Yes – *Submit documentation.* ☐ No

2. Is the patient taking a benzodiazepine? <u>Submit patient's current medication list</u>.
   ☐ Yes – List and provide medical justification:

   ☐ No

3. **Initial requests for all <u>NON-PREFERRED</u> medications**: Does the patient have a history of trial and failure, contraindication, or intolerance to the preferred short-acting opioids analgesics? Check all that apply.
   ☐ APAP/codeine tablet or elixir ☐ hydrocodone/ibuprofen tablet ☐ oxycodone IR tablet
   ☐ Endocet ☐ morphine IR tablet ☐ oxycodone/APAP tablet
   ☐ hydrocodone/APAP tablet ☐ morphine solution or concentrate ☐ tramadol IR tablet
   ☐ Yes ☐ No *Submit documentation of trial & failure, contraindications, or intolerances.*

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. <u>Submit detailed medical record documentation for EACH item.</u>

   <u>INITIAL requests:</u>
   ☐ 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 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 assessed for recent (within the past 60 days) opioid use
   ☐ was evaluated for risk factors for opioid-related harm
      ☐ <u>if identified to be at high risk for opioid-related harm</u>, 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:_____

   <u>RENEWAL requests:</u>
   ☐ 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
      ☐ <u>if identified to be at high risk for opioid-related harm</u>, 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:_____

7. <u>For requests for nasal butorphanol (Stadol)</u>, check all of the following that apply to the beneficiary. Submit documentation for EACH item.
   ☐ the patient is opioid-tolerant (names and dosages of current opioid regimen)
   ☐ <u>if being treated for migraine</u>, has a history of trial & failure of or contraindication or intolerance to abortive (triptans) & preventive medications

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: