SHORT-ACTING OPIOID ANALGESICS PRIOR AUTHORIZATION FORM

(form effective 1/5/21)

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/APAP tablet ☐ morphine solution or concentrate ☐ oxycodone/APAP tablet
   ☐ Benzyhydrocodone/APAP tablet ☐ Lorcet HD tablet ☐ oxycodone 5 mg/5mL solution ☐ tramadol/APAP tablet
   ☐ Endocet ☐ morphine IR tablet ☐ oxycodone IR tablet ☐ 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>
   ☐ pain is caused by a medical condition and is not migraine in type
   ☐ if the patient is under age 21, has severe pain as documented by a pain assessment tool measurement
   ☐ if the patient is age 21 or older, has moderate-to-severe pain as documented by a pain assessment tool measurement
   ☐ 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, and tramadol. Date of last UDS:_____

   For therapeutic duplication only:
   ☐ is being transitioned to or from another short-acting opioid with the intent of discontinuing one of the medications; please provide explanation:

   _____

   ☐ has a medical reason for concomitant use of the requested medications; please provide explanation, including peer-reviewed literature or national guidelines that support the duplication.

   For requests exceeding the quantity limit (check all that apply):
   ☐ medication is being prescribed by or in consultation with an appropriate specialist; list specialty: _____
   ☐ pain is inadequately controlled at the current quantity limit
   ☐ pain is inadequately controlled by, or there is intolerance or contraindication to, other short-acting opioid analgesics
   ☐ pain would not be more appropriately controlled by initiating or adjusting the dose of a long-acting opioid analgesic

CLINICAL INFORMATION

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 for opioid-related harm, the prescriber considered prescribing naloxone
- ☐ if prescribed less than 50 morphine milligram equivalents (MME) per day, has results of a UDS testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, and tramadol) every 12 months. Date of last UDS: _____
- ☐ if prescribed greater than or equal to 50 morphine milligram equivalents (MME) per day, has results of a UDS testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, and tramadol) every 6 months. Date of last UDS: _____

For requests exceeding the quantity limit (check all that apply):

- ☐ if the patient is under age 21, has severe pain as documented by a pain assessment tool measurement
- ☐ if the patient is age 21 or older, has moderate-to-severe pain as documented by a pain assessment tool measurement
- ☐ medication is being prescribed by or in consultation with an appropriate specialist; list specialty: _____
- ☐ pain is inadequately controlled at the current quantity limit
- ☐ pain is inadequately controlled by, or there is intolerance or contraindication to, other short-acting opioid analgesics
- ☐ pain would not be more appropriately controlled by initiating or adjusting the dose of a long-acting opioid analgesic

7. For requests for nasal butorphanol (Stadol), check all of the following that apply to the beneficiary. Submit documentation for EACH item.
   - ☐ the patient is not opioid-tolerant (names and dosages of current opioid regimen)
   - ☐ if being treated for migraine, has a history of trial & failure of or contraindication or intolerance to abortive therapies. Check all that apply:
     - ☐ acetaminophen
     - ☐ NSAIDs
     - ☐ triptans
     - ☐ dihydroergotamine
   - ☐ if being treated for migraine, has a history of trial & failure of or contraindication or intolerance to preventive therapies. Check all that apply:
     - ☐ anticonvulsants
     - ☐ beta-blockers
     - ☐ botulinum toxin
     - ☐ CGRP inhibitors/antagonists
     - ☐ Calcium channel blockers
     - ☐ SNRIs
     - ☐ TCAs
   - ☐ is prescribed treatment by a specialist certified in pain medicine, oncology, or hospice and palliative medicine

8. For requests for transmucosal fentanyl products, check all of the following that apply to the beneficiary. Submit documentation for EACH item.
   - ☐ the patient is opioid-tolerant
   - ☐ is prescribed treatment by a specialist certified in pain medicine, oncology, or hospice and palliative medicine

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: