

LONG-ACTING NARCOTICS for ADULTS ≥ 21 YEARS OF AGE PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Long-Acting Narcotics, please refer to Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Analgesics, Narcotics Long-Acting at <http://www.dhs.state.pa.us/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name: _____		
<input type="checkbox"/> Renewal request	PA#: _____				
Name/phone of office contact: _____			Specialty: _____		
LTC facility contact/phone: _____			NPI: _____	State license: _____	
RECIPIENT INFORMATION			Street address: _____		
Recipient Name: _____			Suite #: _____	City/state/zip: _____	
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____		

CLINICAL INFORMATION

Medication Requested (Names in parentheses are the brand name equivalents for reference purposes.)			
Preferred Agents			
<input type="checkbox"/> fentanyl patch 12 (12.5) mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg (<i>Duragesic</i>)			<input type="checkbox"/> morphine ER tablet (<i>MS Contin</i>)
<input type="checkbox"/> Kadian capsule 10 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg, 100 mg			
Non-Preferred Agents			
<input type="checkbox"/> Belbuca film	<input type="checkbox"/> fentanyl patch (37.5 mcg, 62.5 mcg, 87.5 mcg)	<input type="checkbox"/> methadone solution	<input type="checkbox"/> oxycodone ER tablet (<i>Opana</i>)
<input type="checkbox"/> Butrans patch	<input type="checkbox"/> hydromorphone ER tablet (<i>Exalgo</i>)	<input type="checkbox"/> morphine ER capsule (<i>Avinza</i>)	<input type="checkbox"/> tramadol ER capsule (<i>ConZip</i>)
<input type="checkbox"/> ConZip capsule	<input type="checkbox"/> Hysingla ER tablet	<input type="checkbox"/> morphine ER capsule (<i>Kadian</i>)	<input type="checkbox"/> tramadol ER tablet (<i>Ultram ER</i>)
<input type="checkbox"/> Dolophine tablet	<input type="checkbox"/> Kadian capsule 40 mg, 200 mg	<input type="checkbox"/> Nucynta ER tablet	<input type="checkbox"/> tramadol ER biphasic tablet (<i>Ryzolt</i>)
<input type="checkbox"/> Duragesic patch	<input type="checkbox"/> MS Contin tablet	<input type="checkbox"/> Opana ER tablet	<input type="checkbox"/> Ultram ER tablet
<input type="checkbox"/> Embeda tablet	<input type="checkbox"/> methadone tablet	<input type="checkbox"/> oxycodone ER tablet (<i>OxyContin</i>)	<input type="checkbox"/> Zohydro ER capsule
<input type="checkbox"/> Exalgo tablet		<input type="checkbox"/> OxyContin tablet	<input type="checkbox"/> _____
Strength: _____	Directions: _____	Qty: _____	Duration of therapy: _____
Diagnosis: _____		Diagnosis code (required): _____	

All initial requests

1. Submit documentation of a complete physical exam and pain assessment of the Recipient, including all of the following (check all items that are included in accompanying documentation):

<input type="checkbox"/> complete physical exam	<input type="checkbox"/> duration of pain	<input type="checkbox"/> location & radiation of pain	<input type="checkbox"/> severity of pain using a standard pain assessment tool or scale
<input type="checkbox"/> cause of pain	<input type="checkbox"/> quality of pain	<input type="checkbox"/> palliative & aggravating factors of pain	
2. Check all of the following that apply to the Recipient. Submit detailed medical record documentation for EACH item.

<input type="checkbox"/> had a trial of short-acting opioids	<input type="checkbox"/> has tried or cannot try non-opioid medications for the treatment of pain
<input type="checkbox"/> is opioid-tolerant	<input type="checkbox"/> had counseling regarding potential side effects of opioids, including risk of misuse, abuse, and addiction
<input type="checkbox"/> is receiving palliative care	<input type="checkbox"/> has tried or cannot try non-drug pain management modalities
3. Does the Recipient have a history of, or currently have, substance use disorder [SUD] (Rx or illicit drugs or alcohol)? Submit documentation of a recent evaluation for current or past substance use.

<input type="checkbox"/> Yes → <u>submit results of a recent urine drug screen (UDS) testing for benzodiazepines, opiates (including fentanyl and oxycodone), and illicit drugs.</u>
<input type="checkbox"/> No
4. **For initial requests for a NON-PREFERRED agent**, does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred Long-Acting Narcotics listed above?

<input type="checkbox"/> Yes	<u>Submit documentation of medications tried and treatment outcomes, including intolerances or contraindications.</u>
<input type="checkbox"/> No	

All renewal requests

1. Submit documentation of Recipient's response to the requested medication (severity level, effects on ADLs, etc).
2. Does the Recipient have a current or past substance use disorder [SUD] (Rx or illicit drugs or alcohol)? Submit documentation of a recent evaluation for current or past substance use.

<input type="checkbox"/> Yes → <u>submit results of a recent urine drug screen (UDS) testing for benzodiazepines, opiates (including fentanyl and oxycodone), and illicit drugs.</u>
<input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
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