

NARCOTICS for RECIPIENTS < 21 YEARS OF AGE PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines, refer to Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Analgesics, Narcotics Short-Acting and Analgesics, Narcotics Long-Acting** at <http://www.dhs.state.pa.us/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>.
Refer to the list of **quantity limits** at <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/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 of office contact:			Specialty:		
Contact's phone number:			State license:		
LTC facility contact/phone:			NPI:	MA Provider ID#:	
RECIPIENT INFORMATION			Street address:		
Recipient Name:			Suite #:	City/state/zip:	
Recipient ID#:	DOB:	Phone:	Fax:		

CLINICAL INFORMATION					
Drug Requested:			Strength:	Quantity:	
Directions:			Duration requested:		
Weight:	lbs / kg	Diagnosis:	Diagnosis code (required):		

COMPLETE ALL SECTIONS THAT APPLY TO THE DRUG REQUESTED.

All requests

1. Did the Recipient receive a complete pain assessment?	<input type="checkbox"/> Yes – <i>submit detailed documentation of physical exam and complete pain assessment, including cause, location, severity, duration, quality, etc. of pain</i> <input type="checkbox"/> No
2. Check all of the following that apply to the Recipient. <i>Submit detailed medical record documentation for EACH item.</i>	
<input type="checkbox"/> tried or cannot try non-drug pain management modalities <input type="checkbox"/> tried or cannot try non-opioid medications for the treatment of pain – check drugs tried: <input type="checkbox"/> acetaminophen <input type="checkbox"/> NSAIDs <input type="checkbox"/> other: _____ <input type="checkbox"/> Recipient and/or parent/guardian counseled regarding potential side effects of opioids, including risk of misuse, abuse, and addiction	
3. Did the prescriber assess the Recipient for recent use of a narcotic from any source?	<input type="checkbox"/> Yes – <i>submit documentation of assessment for recent narcotic use</i> <input type="checkbox"/> No
4. Does the Recipient have a history of, or currently have, substance use disorder [SUD] (Rx or illicit drugs or alcohol)?	<input type="checkbox"/> Yes <i>Submit documentation of a recent evaluation for current or past substance use</i> <input type="checkbox"/> No
5. <i>For Recipients with a history of or current SUD</i> , does the Recipient have documentation of a recent urine drug screen (UDS) that is negative for non-prescribed benzodiazepines, opiates (including fentanyl and oxycodone), and illicit drugs?	<input type="checkbox"/> Yes <i>Submit documentation of test results</i> <input type="checkbox"/> No

Requests for long-acting narcotics

1. Did the Recipient have a trial of short-acting narcotics?	<input type="checkbox"/> Yes <i>Submit documentation of short-acting narcotic regimens tried</i> <input type="checkbox"/> No
2. Is the Recipient opioid-tolerant?	<input type="checkbox"/> Yes <i>Submit documentation of current and recent opioid therapy</i> <input type="checkbox"/> No
3. <i>For non-preferred long-acting narcotics</i> , does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred long-acting narcotics? <i>Check all that apply.</i>	<input type="checkbox"/> Yes – <i>submit documentation of trial and failure, contraindications, and intolerances</i> <input type="checkbox"/> No
<input type="checkbox"/> fentanyl patch (12, 25, 50, 75, or 100 mcg) <input type="checkbox"/> Kadian (morphine ER) capsule <input type="checkbox"/> morphine sulfate ER tablet	

Hydromorphone and non-preferred short-acting narcotic requests

1. Check ALL of the following preferred short-acting narcotics that the Recipient has tried and failed or that the Recipient has a contraindication or intolerance to. (Related agents are grouped together.) *Submit documentation of ALL agents tried and failed, contraindications, and intolerances.*

Hydrocodone <input type="checkbox"/> hydrocodone/APAP tablet <input type="checkbox"/> hydrocodone/ibuprofen tablet	Oxycodone <input type="checkbox"/> oxycodone immediate-release tablet <input type="checkbox"/> oxycodone/APAP tablet or Endocet tablet
Hydromorphone <input type="checkbox"/> hydromorphone tablet* (*This agent is preferred and requires clinical prior authorization with documentation that at least 3 other preferred short-acting narcotic analgesics have been tried or cannot be tried.)	Morphine <input type="checkbox"/> morphine immediate-release tablet <input type="checkbox"/> morphine solution <input type="checkbox"/> morphine concentrate solution

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

Prescriber Signature:	Date:
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