pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANALGESICS, NON-OPIOID BARBITURATE COMBINATIONS PRIOR AUTHORIZATION FORM *Form effective 7/23/18*

Prior authorization guidelines are accessible on the Department's Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	NPI:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

Drug: *(products in BOLD and ITALICS are PREFERRED)*

☐Allzital 25/325 mg tablet
☐Bupap tablet
☐butalbital/APAP 50/300 mg tablet
☐butalbital/APAP 50/325 mg tablet
☐butalbital/APAP/caffeine 50/300/40 mg cap
☐***butalbital/APAP/caffeine 50/325/40 mg tab***
☐butalbital/ASA/caffeine 50/325/40 mg cap
☐***butalbital/ASA/caffeine 50/325/40 mg tab***
☐Capacet 50/325/40 mg capsule
☐Esgic 50/325/40 mg capsule
☐Esgic 50/325/40 mg tablet
☐Fioricet 50/300/40 mg capsule
☐Fiorinal 50/325/40 mg capsule
☐Vanatol LQ (or S) solution
☐Zebutal 50/325/40 mg capsule

Directions:	Quantity:	Refills:
Diagnosis:	Dx code (*required*):	

1. Does the beneficiary have a diagnosis of headache based on the most recent International Headache Society Classification of Headache Disorders?	☐Yes ☐No	*Submit documentation of diagnosis or medical literature supporting use for all other indications.*
2. Did the prescriber or prescriber's delegate search the PDMP to review the beneficiary's controlled substance prescription history before issuing this prescription for the requested agent?	☐Yes ☐No	*Submit documentation.*
3. Will the beneficiary be taking another barbiturate or barbiturate-derivative while taking the requested medication, such as phenobarbital or primidone?	☐Yes ☐No	*Submit beneficiary's complete medication list.*
4. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following abortive medications for the treatment of headache? *Check all that apply.* ☐NSAIDs ☐aspirin ☐ergot derivatives ☐triptans ☐acetaminophen ☐OTC analgesic/caffeine combinations	☐Yes ☐No	*Submit documentation of medications tried and outcomes.*
5. ***For non-preferred requests:*** Does the beneficiary have a history of trial & failure of, or contraindication/intolerance to, the preferred Non-Opioid Barbiturate Combos? *Check all that apply.* ☐butalbital/**acetaminophen**/caffeine tablet ☐butalbital/**aspirin**/caffeine tablet	☐Yes ☐No	*Submit documentation of medications tried and outcomes.*
6. ***For beneficiaries aged 65 years and older*:** Has the beneficiary been evaluated and counseled regarding the potential increased risks of the requested medication for older adults (eg, increased risks of physical dependence and overdose at lower doses)?	☐Yes ☐No	*Submit documentation of evaluation and counseling.*
For a diagnosis of CHRONIC DAILY HEADACHE (headache present for ≥ 15 days/month for ≥ 3 months)		
7. Has the beneficiary received a physical and neurologic exam to rule out secondary causes of headache?	☐Yes ☐No	*Submit documentation.*
8. Has the beneficiary been evaluated for the overuse of abortive medications for the treatment of headache (eg, acetaminophen, NSAIDs, triptans, butalbital, caffeine, opioids)?	☐Yes ☐No	*Submit documentation of evaluation.*
9. Has the beneficiary been counseled regarding behavioral modifications for the treatment of chronic daily headache? *Check all that apply.* ☐cessation of caffeine & tobacco ☐diet changes ☐improved sleep hygiene ☐cognitive behavioral therapy ☐regular mealtimes ☐biofeedback/relaxation techniques	☐Yes ☐No	*Submit documentation of counseling by prescriber.*
10. Is the beneficiary currently taking or have a history of trial and failure, contraindication, or intolerance of preventive drug therapy for chronic headache, such as beta blockers, antidepressants, anticonvulsants, calcium channel blockers, etc.?	☐Yes ☐No	*Submit documentation of medications tried and outcomes.*
11. Has the beneficiary been counseled regarding the potential adverse effects of the requested agent, including the risk of medication overuse headache, misuse, abuse, and addiction?	☐Yes ☐No	*Submit documentation of counseling by prescriber.*
12. ***For beneficiaries with a history of substance use disorder***, does the beneficiary have results of a recent urine drug screen testing for licit and illicit drugs (including tramadol, carisoprodol, fentanyl, and oxycodone) with the potential for abuse that is consistent with prescribed controlled substances?	☐Yes ☐No	*Submit UDS results.*

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

Prescriber Signature:	**Date**: