

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

- To review the **prior authorization guidelines** and **quantity limits/daily dose limits** for Short-Acting Narcotics, please refer to Medical Assistance Pharmacy Services webpage at <http://www.dhs.pa.gov/provider/pharmacyservices/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

Drug Requested: _____	Strength: _____	Quantity: _____
Directions: _____	Duration requested: _____	
Diagnosis (<i>submit documentation</i>): _____	Diagnosis code (<i>required</i>): _____	

COMPLETE ALL SECTIONS THAT APPLY TO THE REQUEST.

Hydromorphone and non-preferred 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.*

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

All requests for more than a 14-days' supply or for prior use of a Short-Acting Narcotic Analgesic in the past 180 days

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"/> location and radiation of pain |
| <input type="checkbox"/> imaging and/or other diagnostic testing results | <input type="checkbox"/> palliative and aggravating factors of pain |
| <input type="checkbox"/> cause, duration, and quality of pain | <input type="checkbox"/> severity of pain using a standard pain assessment tool or scale |

2. Check all of the following that apply to the Recipient. *Submit detailed medical record documentation for EACH item.*

- has tried or cannot try non-drug pain management modalities
- has tried or cannot try non-opioid drugs for the treatment of pain – check drugs tried: acetaminophen NSAIDs other: _____
- has been counseled regarding potential side effects of opioids, including risk of misuse, abuse, and addiction
- has been evaluated for current or past substance use, misuse, and abuse
 - For Recipients with current or past substance use disorder, has results of a recent urine drug screen (UDS) that tests for benzodiazepines, opioids (including fentanyl and oxycodone), and illicit drugs*

4. **For requests for oral fentanyl products (e.g., Abstral, Actiq, Fentora, Subsys)**, submit documentation that the Recipient is opioid-tolerant.

5. **For requests for nasal butorphanol (Stadol)**, submit the following documentation:

- the Recipient is opioid-tolerant (names and dosages of current opioid regimen)
- if being treated for migraine*, the Recipient has a history of trial & failure, contraindication, or intolerance of abortive therapies (triptans)
- if being treated for migraine*, the Recipient has a history of trial & failure, contraindication, or intolerance to preventive medications

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

Prescriber Signature: _____	Date: _____
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