LONG-ACTING OPIOID ANALGESICS PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774.**

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:	

MEDICATION REQUESTED (Names in parentheses are the brand name equivalents for reference purposes.)

Preferred Agents

☐ Butrans patch
☐ Embeda ER capsule
☐ Fentanyl patch 12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg (Duragesic)
☐ Morphine ER tablet (MS Contin)

Non-Preferred Agents

☐ Arymo ER tablet
☐ Belbuca film
☐ buprenorphine patch (Butrans)
☐ Dolophine tablet
☐ Duragesic patch
☐ Exalgo tablet
☐ fentanyl patch (37.5, 62.5, 87.5 mcg)
☐ hydromorphone ER tablet (Exalgo)
☐ Hysingla ER tablet
☐ Kadian ER capsule
☐ methadone tablet
☐ methadone solution
☐ Morphabond ER tablet
☐ morphine ER capsule (Avinza)
☐ morphine ER capsule (Kadian)
☐ MS Contin tablet
☐ Nucynta ER tablet
☐ Opana ER tablet
☐ oxycodone ER tablet (OxyContin)
☐ OxyContin tablet
☐ oxymorphone ER tablet (Opana)
☐ tramadol ER capsule (ConZip)
☐ tramadol ER tablet (Ultram ER)
☐ tramadol ER biphasic tablet (Ryzolt)
☐ Xtampza ER capsule
☐ Zohydro ER capsule

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? **Submit patient's current medication list.**
   ☐ Yes – List and provide medical justification:
   ☐ No

3. **For initial requests for a NON-PREFERRED agent**, does the patient have a history of trial and failure, contraindication, or intolerance to the preferred Long-Acting Opioids listed above? ☐ Yes ☐ No Check drugs tried: ☐ fentanyl patch ☐ Embeda ER capsule ☐ morphine ER tablet ☐ Butrans patch

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. **Submit detailed medical record documentation for EACH item.**

INITIAL requests:

☐ 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 recent (within the past 60 days) opioid use
☐ has documentation of a trial of short-acting opioids
☐ is opioid-tolerant
☐ 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 evaluated for risk factors for opioid-related harm ☐ if identified to be at high risk, the prescriber considered prescribing naloxone
☐ has a recent UDS testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, tramadol, and carisoprodol). Date of last UDS:_____

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, the prescriber considered prescribing naloxone
☐ has a recent UDS testing for illicit and licit substances of abuse (with specific testing for oxycodone, fentanyl, tramadol, and carisoprodol). Date of last UDS:_____

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: