# LONG-ACTING OPIOID ANALGESICS PRIOR AUTHORIZATION FORM

(form effective 1/5/21)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

## 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
☐ Fentanyl patch 12 mcg, 25 mcg, 50 mcg, 75 mcg, 100 mcg (Duragesic)
☐ Morphine ER capsule (Kadian)
☐ Morphine ER tablet (MS Contin)
☐ Xtampza ER

**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)
☐ 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)
☐ MS Contin tablet
☐ Nucynta 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)
☐ 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? <u>Submit patient's current medication list</u>.
   ☐ Yes – List and provide medical justification:
   ☐ No

3. **For initial requests for a <u>NON-PREFERRED</u> 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 ☐ morphine ER tablet ☐ morphine ER capsule ☐ Butrans patch ☐ Xtampza ER

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. <u>Submit detailed medical record documentation for EACH item.</u>

**<u>INITIAL requests:</u>**

☐ 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 ☐ <u>if identified to be at high risk</u>, 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:_____

**For therapeutic duplication only:**

☐ is being transitioned to or from another long-acting opioid with the intent of discontinuing one of the medications; please provide explanation:
_____
☐ has a medical reason for concomitant use of the requested medications; please provide explanation including peer-reviewed literature or national guidelines that support the duplication. _____

**For requests exceeding the quantity limit (check all that apply):**

☐ has severe pain as documented by a pain assessment tool measurement
☐ medication is being prescribed by or in consultation with an appropriate specialist; list specialty: _____
☐ pain is inadequately controlled at the current quantity limit
☐ pain is inadequately controlled by, or there is intolerance or contraindication to, other long-acting opioid analgesics
☐ titrating dose or converting from other opioid-containing medications; provide explanation: _____

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

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:_____

**For requests exceeding the quantity limit (check all that apply):**

- ☐ has severe pain as documented by a pain assessment tool measurement
- ☐ medication is being prescribed by or in consultation with an appropriate specialist, list specialty:
- ☐ pain is inadequately controlled at the current quantity limit
- ☐ pain is inadequately controlled by, or there is intolerance or contraindication to, other long-acting opioid analgesics
- ☐ titrating dose or converting from other opioid-containing medications, provide explanation: _____

_____

_____

## PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

| Prescriber signature: | Date: |
|---|---|