

ANALGESICS, NON-OPIOID BARBITURATE COMBINATIONS PRIOR AUTHORIZATION FORM (Form effective 1/1/20)

Prior authorization guidelines and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan's website at

<https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger>

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total # of pgs: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	NPI:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:
Drug requested:			Strength:
Dosage form (tablet, capsule, etc):		Quantity: _____ per _____ days	Refills:
Directions:			
Diagnosis:			Dx code (required):
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?			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
Will the beneficiary be taking another barbiturate or barbiturate-derivative while taking the requested medication, such as phenobarbital or primidone?			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit beneficiary's complete medication</i>
Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following abortive medications for the treatment of headache? <i>Check all that apply.</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of medications tried and outcomes.</i>
<input type="checkbox"/> NSAIDs <input type="checkbox"/> aspirin <input type="checkbox"/> ergot derivatives <input type="checkbox"/> triptans <input type="checkbox"/> acetaminophen <input type="checkbox"/> OTC analgesic/caffeine combinations			
<u>For non-preferred requests</u> Please list the preferred Non-Opioid Barbiturate Combos that the beneficiary has had a therapeutic failure, contraindication, or intolerance to. <i>Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.</i>			<i>Submit documentation of medications tried and outcomes.</i>
<u>For beneficiaries aged 65 years and older:</u> Has the beneficiary been <u>evaluated</u> and <u>counseled</u> regarding the potential increased risks of the requested medication for older adults (eg, increased risks of physical dependence and overdose at lower doses)?			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of evaluation and counseling.</i>
For a diagnosis of CHRONIC DAILY HEADACHE (headache present for ≥ 15 days/month for ≥ 3 months)			
Has the beneficiary received a physical and neurologic exam to rule out secondary causes of headache?			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
Has the beneficiary been evaluated for the overuse of abortive medications for the treatment of headache (eg, acetaminophen, NSAIDs, triptans, butalbital, caffeine, opioids)?			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of evaluation.</i>
Has the beneficiary been counseled regarding behavioral modifications for the treatment of chronic daily headache? <i>Check all that apply.</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of counseling by prescriber.</i>
cessation of caffeine & tobacco diet changes improved sleep hygiene cognitive behavioral therapy regular mealtimes biofeedback/relaxation techniques			
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.?			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of medications tried and outcomes.</i>
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?			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of counseling by</i>
<u>For beneficiaries with a history of substance use disorder,</u> 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?			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit UDS results.</i>

Please submit to PromptPA <https://ghp.promptpa.com> OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation

Prescriber Signature:	Date:
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