GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

ANALGESICS, OPIOID SHORT-ACTING PRIOR AUTHORIZATION FORM *(form effective 01/05/2021)*

Prior authorization guidelines for Analgesics, Opioid Short-Acting 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

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

CLINICAL INFORMATION

Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in each class

Drug requested:	Strength:	Formulation (capsule, tablet, etc):
Directions:		Weight (if < 21 years): _____ lbs / kg
Diagnosis (*submit documentation*):		Dx Code (*required*):
Does the beneficiary have a history of trial and failure, contraindication, or intolerance to other Short-acting Opioid(s)?		☐ Yes Please list: _____ ☐ No
Is the beneficiary being treated for active cancer, sickle cell with crisis, or neonatal abstinence syndrome OR receiving hospice or palliative care services?		☐ Yes – *Submit documentation and send to GHP* ☐ No – *Continue with form.*
What is the anticipated duration of therapy with opioid analgesics?		Requested duration:_____days / 1 mo / 2 mos / 3 mos
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 – specify: _____ ☐ No
If taking a benzodiazepine, is there a plan for the tapering of the benzodiazepine(s)?		☐ Yes ☐ No
If taking a benzodiazepine, is there documentation that the member has been counseled on the increased risk of death associated with concurrent benzodiazepine and opioid use AND has been offered naloxone		☐ Yes ☐ No

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INITIAL requests

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

INITIAL requests:

Member has a documentation of pain that is ALL of the following: ☐Caused by a medical condition ☐Not neuropathic or migraine in type

- ☐ has documentation of a complete physical exam, including diagnostic testing/imaging results (cause, severity, location, etc), and documentation by a pain assessment tool measurement (e.g., a numeric or visual analog scale) Result of numeric or visual analog scale:_____
- ☐ has documentation of therapeutic failure, contraindication, or intolerance to non-pharmacologic techniques (e.g., behavioral, cognitive, physical, and/or supportive therapies)
- ☐ has tried or cannot try non-opioid drugs for the treatment of pain:
  - ☐ acetaminophen
  - ☐ Cymbalta (duloxetine)
  - ☐ Gabapentin
  - ☐ NSAIDs (e.g., ibuprofen, naproxen, meloxicam, etc.)
  - ☐ Lyrica (pregabalin)
  - ☐ tricyclic antidepressants (e.g., amitriptyline, nortriptyline, ect.)
  - ☐ other (specify): _____
- ☐ Will use the requested opioid in combination with tolerated non-drug therapies and non-opioid drugs
- ☐ Was assessed for the potential risk of misuse, abuse, and addiction based on family and social history obtained by prescriber
- ☐ Was counseled about the potential side effects of opioids, including the risk for misuse, abuse, and addiction
- ☐ If under 21 years of age, a parent/guardian was counseled about the potential side effects of opioids, including the risk for misuse, abuse, and addiction
- ☐ Was evaluated for risk factors for opioid-related harm
  - ☐ Determined to be at high-risk for opioid-related harm
  - ☐ The prescriber considered prescribing naloxone for the beneficiary
- ☐ Was assessed for recent use of opioids (within the past 60 days)
- ☐ Has results of a recent urine drug screen (UDS) testing for licit and illicit drugs with the potential for abuse, including specific testing for oxycodone, fentanyl, and tramadol that is consistent with prescribed controlled substances Date of last UDS Test _____
- ☐ The requested medication is a transmucosal fentanyl product
  - ☐ Has a diagnosis of cancer
  - ☐ Is opioid-tolerant
  - ☐ Is prescribed transmucosal fentanyl by a specialist certified in pain medicine, oncology, or hospice and palliative medicine
  - ☐ Has a contraindication to the preferred Analgesics, Opioid Short-Acting (*refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class*)
- ☐ The requested medication is a nasal butorphanol product
  - ☐ Is not opioid-tolerant
  - ☐ Is being treated for migraine
  - ☐ Is prescribed nasal butorphanol by a neurologist or headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties
  - ☐ Tried and failed or has a contraindication or intolerance to the following abortive medications:
    - ☐ Acetaminophen
    - ☐ NSAIDs
    - ☐ Triptans
    - ☐ Dihydroergotamine
  - ☐ Tried and failed or has a contraindication or intolerance to the following preventive medications:
    - ☐ Anticonvulsants
    - ☐ Beta blockers
    - ☐ Botulinum toxins
    - ☐ CGRP inhibitors
    - ☐ Calcium channel blockers
    - ☐ SNRIs
    - ☐ Tricyclic antidepressants
  - ☐ Is being treated for non-migraine pain
    - ☐ Is prescribed nasal butorphanol by a specialist certified in neurology, pain medicine, oncology, or hospice and palliative care medicine
    - ☐ Tried and failed or has a contraindication or intolerance to at least 3 unrelated (ie, different opioid ingredient) preferred Analgesics, Opioid Short-Acting

RENEWAL requests

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

- ☐ Experienced an improvement in pain control and/or level of functioning while on the requested medication
- ☐ Will use the requested opioid in combination with tolerated non-drug therapies and non-opioid drugs
- ☐ Was recently evaluated 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
  - ☐ Determined to be at high-risk for opioid-related harm
  - ☐ The prescriber considered prescribing naloxone for the beneficiary
- ☐ Has results of a recent urine drug screen (UDS) testing for licit and illicit drugs with the potential for abuse, including specific testing for oxycodone, fentanyl, and tramadol that is consistent with prescribed controlled substances Date of last UDS Test: _____

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: