pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

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 the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐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?	☐Yes ☐No	*Submit documentation.*
Will the beneficiary be taking another barbiturate or barbiturate-derivative while taking the requested medication, such as phenobarbital or primidone?	☐Yes ☐No	*Submit beneficiary's complete medication list.*
Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following abortive medications for the treatment of headache? *Check all that apply.* ☐NSAIDs ☐aspirin ☐ergot derivatives ☐triptans ☐acetaminophen ☐OTC analgesic/caffeine combinations	☐Yes ☐No	*Submit documentation of medications tried and outcomes.*
For non-preferred requests: Does the beneficiary have a history of trial & failure of, or contraindication/intolerance to, the preferred Non-Opioid Barbiturate Combos? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes ☐No	*Submit documentation of medications tried and outcomes.*
***For beneficiaries aged 65 years and older*:** Has the beneficiary been evaluated and counseled regarding the potential increased risks of the requested medication for older adults (eg, increased risks of physical dependence and overdose at lower doses)?	☐Yes ☐No	*Submit documentation of evaluation and counseling.*
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?	☐Yes ☐No	*Submit documentation.*
Has the beneficiary been evaluated for the overuse of abortive medications for the treatment of headache (eg, acetaminophen, NSAIDs, triptans, butalbital, caffeine, opioids)?	☐Yes ☐No	*Submit documentation of evaluation.*
Has the beneficiary been counseled regarding behavioral modifications for the treatment of chronic daily headache? *Check all that apply.* ☐cessation of caffeine & tobacco ☐diet changes ☐improved sleep hygiene ☐cognitive behavioral therapy ☐regular mealtimes ☐biofeedback/relaxation techniques	☐Yes ☐No	*Submit documentation of counseling by prescriber.*
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.?	☐Yes ☐No	*Submit documentation of medications tried and outcomes.*
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?	☐Yes ☐No	*Submit documentation of counseling by prescriber.*
For beneficiaries with a history of substance use disorder, 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?	☐Yes ☐No	*Submit UDS results.*

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

Prescriber Signature:	**Date**: