Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Analgesics, Acute Pain Agents

A. Prescriptions that Require Prior Authorization

All prescriptions for Analgesics, Acute Pain Agents must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Analgesics, Acute Pain Agent, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed for the treatment of a diagnosis that is indicated in the U.S. Food and Drug (FDA)-approved package labeling or a medically accepted indication; **AND**

2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Does not have a contraindication to the prescribed drug; **AND**

5. Has a history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:

   a. Acetaminophen
   b. An NSAID;
   AND

6. For Journavx (suzetrigine), **both** of the following:

   a. Has not received a 14-day supply of Journavx (suzetrigine) in the past 90 days
   b. If Journavx (suzetrigine) has been used in the past, has documentation that the beneficiary is experiencing a new episode of moderate to severe acute pain that is separate and distinct from the previous episode that was treated with Journavx (suzetrigine);
   AND

7. For a non-preferred Analgesics, Acute Pain Agent, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Analgesics, Acute Pain Agents. See the Preferred Drug List for the list of preferred Analgesics, Acute Pain Agents at: https://papdl.com/preferred-drug-list;

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Analgesics, Acute Pain Agent. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

Requests for prior authorization of Journavx (suzetrigine) will be approved for up to 14 days.

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ANALGESICS, ACUTE PAIN AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

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

CLINICAL INFORMATION

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

For ALL requests: Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to both of the following? ☐Acetaminophen ☐An NSAID	☐Yes ☐No *Submit documentation.*
For JOURNAVX (suzetrigine): Has the beneficiary received a 14-day supply of Journavx (suzetrigine) in the past 90 days?	☐Yes ☐No *Submit documentation.*
For JOURNAVX (suzetrigine): If the beneficiary has used Journavx (suzetrigine) in the past, is the beneficiary experiencing a new episode of moderate to severe acute pain that is separate and distinct from the previous episode that was treated with Journavx (suzetrigine)?	☐Yes ☐No ☐N/A *Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:	**Date**: