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

I. Requirements for Prior Authorization of Analgesics, Opioid Short-Acting

A. Prescriptions That Require Prior Authorization

Prescriptions for Analgesics, Opioid Short-Acting that meet any of the following conditions must be prior authorized:

1. A non-preferred Analgesic, Opioid Short-Acting. See the Preferred Drug List (PDL) for the list of preferred Analgesics, Opioid Short-Acting at: https://papdl.com/preferred-drug-list.
2. An Analgesic, Opioid Short-Acting when there is a record of a recent paid claim for another drug within the same therapeutic class of drugs in the point-of-sale online claims adjudication system (therapeutic duplication).
3. An Analgesic, Opioid Short-Acting when a beneficiary has a concurrent prescription for a buprenorphine agent with a U.S. Food and Drug Administration (FDA)-approved indication for opioid use disorder OR naltrexone for extended-release injectable suspension (Vivitrol).
4. An Analgesic, Opioid Short-Acting that contains codeine or tramadol when prescribed for a beneficiary under 18 years of age.
5. An Analgesic, Opioid Short-Acting that does not contain codeine or tramadol when prescribed for a beneficiary under 18 years of age and at least **one** of the following:
   a. More than a five-day supply is prescribed.
   b. The beneficiary has a history of a paid claim for an Analgesic, Opioid Short-Acting within the past 180 days.
6. An Analgesic, Opioid Short-Acting when prescribed for a beneficiary 18 years of age or older and at least **one** of the following:
   a. More than a 10-day supply is prescribed.
   b. The beneficiary has a history of a paid claim for an Analgesic, Opioid Short-Acting within the past 180 days.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Analgesic, Opioid Short-Acting, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a transmucosal fentanyl product, **all** of the following:
   a. Has a diagnosis of cancer,
   b. Is opioid-tolerant,[1]
   c. Is prescribed the requested transmucosal fentanyl product by a specialist certified in pain medicine, oncology, or hospice and palliative medicine by the American Board of Medical Specialties,
   d. Has a history of a contraindication to the preferred Analgesics, Opioid Short-Acting;

[1] Opioid tolerant is defined as taking at least morphine 60 mg/day, transdermal fentanyl 25 mcg/hour, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for one (1) week or longer.

AND

2. For nasal butorphanol, **both** of the following:

   a. Is not opioid-tolerant[1]

   b. **One** of the following:

      i. **All** of the following:

         a) Has a diagnosis of pain,
         b) Is being prescribed nasal butorphanol by a specialist certified in neurology, pain medicine, oncology, or hospice and palliative medicine by the American Board of Medical Specialties,
         c) Has a history of therapeutic failure of or a contraindication or an intolerance to at least three unrelated (i.e., different opioid ingredient) preferred Analgesics, Opioid Short-Acting (single-entity or combination products)

      ii. **All** of the following:

         a) Has a diagnosis of migraine,

         b) Is prescribed nasal butorphanol by a neurologist or headache specialist who is certified in headache medicine by the United Council for Neurologic Subspecialties,

         c) Has a history of therapeutic failure of or a contraindication or an intolerance to **all** of the following abortive therapies:

            (i) Acetaminophen,
            (ii) Non-steroidal anti-inflammatory drugs (NSAIDs),
            (iii) Triptans,
            (iv) Dihydroergotamine,

         d) Has a history of therapeutic failure of or a contraindication or an intolerance to **all** of following preventive therapies:

            (i) Anticonvulsants,
            (ii) Beta blockers,
            (iii) Botulinum toxin (for a diagnosis of chronic migraine only),
            (iv) Calcitonin gene-related peptide inhibitors/antagonists,
            (v) Calcium channel blockers,
            (vi) Serotonin-norepinephrine reuptake inhibitors,
            (vii) Tricyclic antidepressants;

   AND

3. For a combination agent containing a barbiturate, also meets the prior authorization guideline related to Analgesics, Non-Opioid Barbiturate Combinations; **AND**

4. For a non-preferred Analgesic, Opioid Short-Acting, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Analgesics, Opioid Short-Acting; **AND**

5. For a beneficiary with a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder OR naltrexone for extended-release injectable suspension (Vivitrol), is prescribed both prescriptions by the same prescriber or, if prescribed by different prescribers, all prescribers are aware of the other prescription(s);

   AND

6. For therapeutic duplication, **one** of the following:
   a. Is being transitioned to or from another Analgesic, Opioid Short-Acting with the intent of discontinuing one of the drugs
   b. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed literature or national treatment guidelines;

   AND

7. **One** of the following:

   a. **One** of the following:

      i. For a beneficiary under 18 years of age, **both** of the following:

         a) Has a diagnosis of active cancer, sickle cell with crisis, or neonatal abstinence syndrome or is receiving palliative care or hospice services or is receiving treatment post-operatively or following a traumatic injury
         b) The Analgesic, Opioid Short-Acting does not contain codeine or tramadol

      ii. For a beneficiary 18 years of age or older, has a diagnosis of active cancer or sickle cell with crisis or is receiving palliative care or hospice services or is receiving treatment post-operatively or following a traumatic injury

   b. **All** of the following:

      i. Has documentation of pain that is **all** of the following:

         a) Caused by a medical condition,
         b) Moderate to severe,
         c) For all Analgesics, Opioid Short-Acting except nasal butorphanol, not migraine in type,

      ii. Has a history of therapeutic failure of or a contraindication or an intolerance to non-opioid analgesics (e.g., acetaminophen, NSAIDs, gabapentinoids, duloxetine, tricyclic antidepressants) appropriate for the beneficiary's condition,

      iii. Was assessed for potential risk of opioid misuse or use disorder by the prescribing provider,

      iv. Is prescribed a dose that is appropriate based on FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

      v. Is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined to be medically necessary,

vi. For beneficiaries who have received opioid treatment for the past three months, 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, buprenorphine, and tramadol) that is consistent with prescribed controlled substances,

vii. For a beneficiary under 18 years of age, is prescribed a drug and dose that is appropriate based on the beneficiary's age, weight, and concurrent medical conditions and is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature;

AND

8. If a prescription for an Analgesic, Opioid Short-Acting is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will take into account **both** of the following:

   a. An opioid analgesic at the requested dose is the most appropriate treatment option as documented by at least **one** of the following:

      i. Pain is inadequately controlled at the current quantity limit
      ii. Pain is inadequately controlled by other Analgesics, Opioid Short-Acting or the beneficiary has a history of a contraindication or adverse reaction to alternative Analgesics, Opioid Short-Acting

   b. The beneficiary would not be more appropriately pain controlled by initiating or adjusting the dose of an Analgesic, Opioid Long-Acting.

   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. When the above guidelines are not met but the beneficiary is receiving ongoing opioid therapy, a one-month approval will be issued to avoid abrupt discontinuation while the requested information to determine medical necessity is submitted.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR ANALGESICS, OPIOID SHORT-ACTING: The determination of medical necessity of a request for renewal of a prior authorization for an Analgesic, Opioid Short-Acting that was previously approved will take into account whether the beneficiary:

1. **One** of the following:

   a. **One** of the following:

      i. For a beneficiary under 18 years of age, **both** of the following:

         a) Has a diagnosis of active cancer, sickle cell with crisis, or neonatal abstinence syndrome or is receiving palliative care or hospice services
         b) The Analgesic, Opioid Short-Acting does not contain codeine or tramadol

      ii. For a beneficiary 18 years of age or older, has a diagnosis of active cancer or sickle cell with crisis or is receiving palliative care or hospice services

b. **All** of the following:

i. Has documentation of improvement in pain control and/or level of functioning while on the requested drug,
ii. Is not taking a benzodiazepine, unless the benzodiazepine or opioid is being tapered or concomitant use is determined to be medically necessary,
iii. Has results of a UDS testing for licit and illicit drugs with the potential for abuse (including specific testing for oxycodone, fentanyl, buprenorphine, and tramadol) at least every 12 months that is consistent with prescribed controlled substances

AND

2. If a prescription for an Analgesic, Opioid Short-Acting is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will take into account **both** of the following:

a. An opioid analgesic at the requested dose is the most appropriate treatment option as documented by at least **one** of the following:

i. Pain is inadequately controlled at the current quantity limit
ii. Pain is inadequately controlled by other Analgesics, Opioid Short-Acting or the beneficiary has a history of a contraindication or adverse reaction to alternative Analgesics, Opioid Short-Acting

b. The beneficiary would not be more appropriately pain controlled by initiating or adjusting the dose of an Analgesic, Opioid Long-Acting.

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. When the above guidelines are not met but the beneficiary is receiving ongoing opioid therapy, a one-month approval will be issued to avoid abrupt discontinuation while the requested information to determine medical necessity is submitted.

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 Analgesic, Opioid Short-Acting. 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 an Analgesic, Opioid Short-Acting will be approved for up to six months.

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ANALGESICS, OPIOID SHORT-ACTING PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

☐New request ☐Renewal request	# of 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:	Formulation (capsule, tablet, etc.):
Directions:		Weight (if <21 years of age):
Quantity per fill: _____ to last _____ days		Requested duration:
Diagnosis *(submit documentation)*:		Dx code (*required*):

- **Pennsylvania law requires prescribers to query the PA PDMP each time a patient is prescribed an opioid drug product or benzodiazepine.**
- **Naloxone is available at Pennsylvania pharmacies via standing order from the Secretary of the Department of Health. Pennsylvania Medical Assistance beneficiaries may obtain naloxone free-of-charge through their prescription drug benefit.**

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

INITIAL requests

1. For a transmucosal fentanyl product:
- ☐Has a diagnosis of cancer
- ☐Is opioid-tolerant (opioid-tolerant is defined as taking at least morphine 60 mg/day, transdermal fentanyl 25 mcg/hour, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for one week or longer)
- ☐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

2. For nasal butorphanol:
- ☐Is not opioid-tolerant (opioid-tolerant is defined as taking at least morphine 60 mg/day, transdermal fentanyl 25 mcg/hour, oxycodone 30 mg/day, oral hydromorphone 8 mg/day, or an equianalgesic dose of another opioid for one week or longer)
- ☐Is being treated for **migraine** and**:**
  - ☐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 an intolerance to the following abortive medications:
    - ☐acetaminophen ☐triptans
    - ☐NSAIDs ☐dihydroergotamine
  - ☐Tried and failed or has a contraindication or an intolerance to the following preventive medications:
    - ☐anticonvulsants ☐botulinum toxins ☐calcium channel blockers ☐tricyclic antidepressants
    - ☐beta blockers ☐CGRP inhibitors ☐SNRIs
- ☐Is being treated for **non-migraine pain** and**:**
  - ☐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 (i.e., different opioid ingredient) preferred Analgesics, Opioid Short-Acting *(See the Preferred Drug List for the list of preferred Analgesics, Opioid Short-Acting at: https://papdl.com/preferred-drug-list)*

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3. **For a non-preferred Analgesic, Opioid Short-Acting** *(See the Preferred Drug List for the list of preferred and non-preferred Analgesics, Opioid Short-Acting at: https://papdl.com/preferred-drug-list)*:
   - ☐ Tried and failed or has a contraindication or an intolerance to the preferred Analgesics, Opioid Short-Acting

4. **For a beneficiary with a concurrent prescription for a buprenorphine agent indicated for the treatment of opioid use disorder (OUD) OR Vivitrol (naltrexone extended-release suspension for injection):**
   - ☐ Both prescriptions are prescribed by the same prescriber
   - ☐ Prescriptions are prescribed by different prescribers and all prescribers are aware of the other prescription(s)
   - ☐ Not applicable – beneficiary is not taking a buprenorphine agent indicated for the treatment of OUD or Vivitrol

5. **For all Analgesics, Opioid Short-Acting:**
   - ☐ Has a diagnosis of active cancer, sickle cell with crisis, or neonatal abstinence syndrome
   - ☐ Is receiving palliative care or hospice services
   - ☐ Is receiving treatment post-operatively or following a traumatic injury
   - ☐ Has documentation of pain that is all of the following:
     - ☐ Caused by a medical condition
     - ☐ Moderate to severe
     - ☐ Not migraine in type *(does NOT apply to nasal butorphanol)*
   - ☐ Tried and failed or has a contraindication or an intolerance to non-opioid analgesics appropriate for the beneficiary's condition:
     - ☐ acetaminophen
     - ☐ duloxetine (e.g., Cymbalta, Drizalma)
     - ☐ gabapentinoids (e.g., gabapentin, pregabalin [Lyrica])
     - ☐ NSAIDs (e.g., ibuprofen, naproxen, meloxicam, etc.)
     - ☐ tricyclic antidepressants (e.g., amitriptyline, nortriptyline, etc.)
     - ☐ other (specify): _____
   - ☐ Was assessed for the potential risk of opioid misuse or opioid use disorder by the prescriber

6. **For a beneficiary with a concurrent prescription for a benzodiazepine:**
   - ☐ The benzodiazepine is being tapered
   - ☐ The opioid is being tapered
   - ☐ Concomitant use of the benzodiazepine and opioid is medically necessary
   - ☐ Not applicable – beneficiary is not taking a benzodiazepine

7. **For a beneficiary who has received opioid treatment for the past 3 months:**
   - ☐ 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, buprenorphine, and tramadol, that is consistent with prescribed controlled substances

RENEWAL requests

1. **For all Analgesics, Opioid-Short Acting:**
   - ☐ Has a diagnosis of active cancer, sickle cell with crisis, or neonatal abstinence syndrome
   - ☐ Is receiving palliative care or hospice services
   - ☐ Experienced an improvement in pain control and/or level of functioning while on the requested medication
   - ☐ 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, buprenorphine, and tramadol, at least every 12 months that is consistent with prescribed controlled substances

2. **For a beneficiary with a concurrent prescription for a benzodiazepine:**
   - ☐ The benzodiazepine is being tapered
   - ☐ The opioid is being tapered
   - ☐ Concomitant use of the benzodiazepine and opioid is medically necessary
   - ☐ Not applicable – beneficiary is not taking a benzodiazepine

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:	**Date**: