

I. Requirements for Prior Authorization of Analgesics, Non-Opioid Barbiturate Combinations

A. Prescriptions That Require Prior Authorization

All prescriptions for Analgesics, Non-Opioid Barbiturate Combinations must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of an Analgesics, Non-Opioid Barbiturate Combination, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Analgesics, Non-Opioid Barbiturate Combination for a diagnosis that is included in the U.S. Food and Drug Administration (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. For a beneficiary 65 years of age or older, **both** of the following:
 - a. Received a risk assessment by the prescriber and the prescriber indicated that the benefits of the requested drug outweigh the risks for the beneficiary
 - b. Has been counseled by the prescriber regarding the potential increased risks of the requested drug;

AND

5. Is not taking primidone or other drug(s) containing a barbiturate; **AND**
6. Will not be taking the requested drug on more than three days per month; **AND**
7. Has a diagnosis of headache based on the current International Headache Society Classification of Headache Disorders; **AND**
8. Has a history of therapeutic failure of or a contraindication or an intolerance to standard abortive drugs based on headache classification as recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, and American Headache Society); **AND**
9. If being treated for chronic daily headache, defined as the presence of headache on 15 days or more per month for at least three months, **all** of the following:

- a. Has results of a physical examination and complete neurologic examination to rule out secondary causes of headache,
- b. Had an evaluation for the overuse of abortive drugs, including but not limited to acetaminophen, NSAIDs, triptans, butalbital, caffeine, and opioids,
- c. Has been counseled by the prescriber regarding behavioral modifications, such as cessation of caffeine and tobacco use, improved sleep hygiene, diet changes, and regular mealtimes,
- d. **One** of the following:
 - i. Is taking preventive drug therapy based on headache classification as recommended by current consensus guidelines (such as guidelines from the American Academy of Neurology, American Academy of Family Physicians, and American Headache Society)
 - ii. Has a contraindication or an intolerance to standard preventive drug therapies,
- e. Has been counseled by the prescriber regarding the potential adverse effects of Analgesics, Non-Opioid Barbiturate Combinations, including the risk of medication overuse headache, misuse, abuse, and addiction,
- f. For a beneficiary with a history of substance use disorder, has results of a recent urine drug screen 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;

AND

- 10. For a non-preferred Analgesics, Non-Opioid Barbiturate Combination, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Analgesics, Non-Opioid Barbiturate Combinations. See the Preferred Drug List (PDL) for the list of preferred Analgesics, Non-Opioid Barbiturate Combinations at: <https://papdl.com/preferred-drug-list>; **AND**

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, Non-Opioid Barbiturate Combination. 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.

ANALGESICS, NON-OPIOID BARBITURATE COMBINATIONS

PRIOR AUTHORIZATION FORM (form effective 1/6/2025)

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pgs: _____	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:	
Dosage form (tablet, capsule, etc):	Quantity: _____ per _____ days	Refills:	
Directions:			
Diagnosis:		Dx code (<u>required</u>):	

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

1. For ALL requests:

- ☐ Is not taking primidone or any other drug(s) containing a barbiturate (e.g., phenobarbital)
- ☐ Will not take the requested drug on more than 3 days per month
- ☐ Has a diagnosis of headache based on the current International Headache Society Classification of Headache Disorders
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to standard abortive drugs for the treatment of headache based on headache classification:
 - ☐ acetaminophen
 - ☐ analgesic/caffeine combinations (e.g., Excedrin)
 - ☐ aspirin
 - ☐ NSAIDs
 - ☐ other: _____

2. For a beneficiary 65 YEARS OF AGE OR OLDER:

- ☐ The benefits of the requested drug outweigh the increased risks based on the prescriber's assessment
- ☐ Was counseled by the prescriber regarding the potential increased risks of the requested drug

3. For the treatment of CHRONIC DAILY HEADACHE (presence of headache on 15 or more days per month for at least 3 months):

- ☐ Secondary causes of headache ruled out based on a physical exam
- ☐ Secondary causes of headache ruled out based on a complete neurological exam
- ☐ Was evaluated for the overuse of abortive drugs for the treatment of headache, including acetaminophen, butalbital, caffeine, NSAIDs, opioids, and triptans

- ☐ Was counseled regarding behavioral modifications, such as cessation of caffeine and tobacco use, improved sleep hygiene, dietary changes, and regular mealtimes
- ☐ Is currently taking preventive drug therapy based on headache classification or has a contraindication or an intolerance to preventive drug therapies:
- ☐ tricyclic antidepressants (e.g., amitriptyline, nortriptyline, protriptyline)
 - ☐ other antidepressants (e.g., mirtazapine, SNRIs [e.g., venlafaxine])
 - ☐ anticonvulsants (e.g., gabapentin, topiramate)
 - ☐ tizanidine (Zanaflex)
 - ☐ other: _____
- ☐ Was counseled regarding the potential adverse effects of the requested drug, including the risk of medication overuse headache, misuse, abuse, and addiction
- ☐ Has a history of substance use disorder AND:
- ☐ Has results of a recent urine drug screen 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

4. For a NON-PREFERRED Analgesic, Non-Opioid Barbiturate Combination:

- ☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Analgesics, Non-Opioid Barbiturate Combinations that are approved or medically accepted for treatment of the beneficiary's diagnosis (*Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.*)

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:

Date:

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