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

## 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 Analgesic, 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 Analgesic, Non-Opioid Barbiturate Combination for an indication 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. If age 65 years or older, **both** of the following:

   a Received a risk assessment by the prescriber and the prescriber indicated that the benefits of the requested medication outweigh the risks for the beneficiary
   b Has documentation of prescriber counseling regarding the potential increased risks of the requested medication;

**AND**

4. Is not taking primidone or other medication(s) containing a barbiturate; **AND**

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

6. Will not be taking the requested medication on more than three (3) 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 trial and failure, intolerance, or contraindication of standard abortive medication based on headache classification as recommended by the most recent American Academy of Neurology, American Academy of Family Physicians, World Health Organization, or European Academy of Neurology treatment guidelines; **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 (3) months, **all** of the following:

a Has documentation of results of a physical examination and complete neurologic examination to rule out secondary causes of headache,

b Has documentation of an evaluation for the overuse of abortive medications, including but not limited to acetaminophen, NSAIDs, triptans, butalbital, caffeine, and opioids,

c Has documentation of prescriber counseling 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 the most recent American Academy of Neurology, American Academy of Family Physicians, World Health Organization, or European Academy of Neurology treatment guidelines
ii. Has a contraindication or intolerance of standard preventive drug therapies,

e Has documentation of prescriber counseling 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 (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;

**AND**

10. Is being treated by a prescribing provider who confirms that he/she, or the prescribing provider's delegate, conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the beneficiary's controlled substance prescription history before prescribing the Analgesic, Non-Opioid Barbiturate Combination; **AND**

11. For a non-preferred Analgesic, Non-Opioid Barbiturate Combination, has a history of therapeutic failure, contraindication, or intolerance of the preferred Analgesic, 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

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 Analgesic, 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.

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# ANALGESICS, NON-OPIOID BARBITURATE COMBINATIONS PRIOR AUTHORIZATION FORM (*Form effective 1/1/20*)

| | | | |
|---|---|---|---|
| ☐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: |
| Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode: ) | | Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other | |
| Drug requested: | | | Strength: |
| Dosage form (tablet, capsule, etc): | | Quantity: _____ per _____ days | Refills: |
| Directions: | | | |
| Diagnosis: | | Dx code (*required*): | |

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| 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*.<br>☐NSAIDs ☐aspirin ☐ergot derivatives<br>☐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*.<br>☐cessation of caffeine & tobacco ☐diet changes ☐improved sleep hygiene<br>☐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 TO HIGHMARK WHOLECARE – PHARMACY DIVISION

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| Prescriber Signature: | Date: |