Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Analgesics, Opioids Short-Acting

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Additional Information:

Q2. Weight:

Q3. Quantity per fill _____ to last _____ days

Q4. Duration:

Q5. Diagnosis:

Q6. Diagnosis Code:

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Patient Name:	**Prescriber Name:**

Q7. Type of request:

☐ Initial Request ☐ Renewal Request

Q8. 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 (See the Preferred Drug List for the list of preferred Analgesics, Opioid Short-Acting at: https://papdl.com/preferred-drug-list)

Q9. 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)

☐ Yes ☐ No

Q10. For nasal butorphanol: 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

☐ Yes ☐ No

Q11. For nasal butorphanol: Is being treated for migraine and:

Tried and failed or has a contraindication or an intolerance to the following abortive medications:

☐ acetaminophen
☐ NSAIDS
☐ triptans

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Patient Name:	**Prescriber Name:**

☐ dihydroergotamine

Q12. For nasal butorphanol: Is being treated for migraine and:

Tried and failed or has a contraindication or an intolerance to the following preventive medications:

☐ anticonvulsants
☐ beta blockers
☐ botulinum toxins
☐ CGRP inhibitors
☐ calcium channel blockers
☐ SNRIs
☐ tricyclic antidepressants

Q13. For nasal butorphanol: 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)

Q14. For a non-formulary 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

☐ N/A

Q15. 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):

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Patient Name:	**Prescriber Name:**

☐ 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

Prescriber Signature

Date

2024 Prior Authorization Request