ANALGESICS, NON-OPIOID BARBITURATE COMBINATIONS PRIOR AUTHORIZATION FORM

(form effective 1/6/2025)

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	
Name of office contact:	Contact's phone number:	LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:	Phone:	

PRESCRIBER INFORMATION

Prescriber name:			
Specialty:		NPI:	State license #:
Street address:			
Suite #:	City/state/zip:		
Phone:		Fax:	

CLINICAL INFORMATION

Preferred:	Non-Preferred:		
☐ Butalbital-Acetaminophen-Caffeine 50-325-40 mg Tablet ☐ Butalbital-Aspirin-Caffeine 50-325-40 mg Capsule	☐ Bupap 50-300 mg Tablet ☐ Butalbital-Acetaminophen 50-300 mg Capsule ☐ Butalbital-Acetaminophen 50-300 mg Tablet	☐ Butalbital-Acetaminophen 50-325 mg Tablet ☐ Butalbital-Acetaminophen-Caffeine 50-300-40 mg Capsule ☐ Butalbital-Acetaminophen-Caffeine 50-325-40 mg Capsule	☐ Esgic Capsule ☐ Esgic Tablet ☐ Fioricet 50-300-40 mg Capsule ☐ Zebutal 50-325-40 mg Capsule

Dosage form (tablet, capsule, etc):	Strength:	Quantity: _____ per _____ days	Refills:
Directions:			
Diagnosis:			Dx code *(required)*:

INITIAL REQUESTS

Complete all sections that apply to the beneficiary and this request.
Check all that apply 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

INITIAL REQUESTS

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.)*

☐ List medications tried:_____

5. For a request OVER the plan quantity limit:

☐ The quantity prescribed is consistent with medically accepted prescribing practices and standards of care, including support from peer-reviewed literature or national treatment guidelines that corroborate use of the quantity of medication being prescribed for treatment of patient's condition (submit documentation of peer-reviewed literature or national treatment guidelines)

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: