

JOB AID

Pharmacy Provider Prior Approval Short-Acting and Long-Acting Preferred and Non-Preferred Drugs

Contents

Overview	2
Log In to the Provider Portal	2
Requesting a Prior Approval	3
Prior Approval Request – Prior Approval Request Type	4
Prior Approval Request – Long-Acting Opioid Analgesics – Preferred	5
Long-Acting Preferred Opioid Analgesics	5
Diagnosis of Malignant Cancer or Pain Due to Neoplasm	8
No Diagnosis of Malignant Cancer or Pain Due to Neoplasm	10
Prior Approval Request – Long-Acting Opioid Analgesics – Non-Preferred	12
Long-Acting Non-Preferred Opioid Analgesics	12
Diagnosis of Malignant Cancer or Pain Due to Neoplasm	15
No Diagnosis of Malignant Cancer or Pain Due to Neoplasm	16
Prior Approval Request – Short-Acting Opioid Analgesics – Preferred	20
Short-Acting Preferred Opioid Analgesics	20
Diagnosis of Malignant Cancer or Pain Due to Neoplasm	22
No Diagnosis of Malignant Cancer or Pain Due to Neoplasm	23
Prior Approval Request – Short-Acting Opioid Analgesics – Non-Preferred	25
Short-Acting Non-preferred Opioid Analgesics	25
Diagnosis of Malignant Cancer or Pain Due to Neoplasm	28
No Diagnosis of Malignant Cancer or Pain Due to Neoplasm	30
Appendix A. Morphine Equivalency Values	34
Appendix B. Pharmacy Edit Updates	35
B.1 Edit 59060	35
B.2 Edit 01099	35
B.3 Edit 01100	35
B.4 Edit 01101	35

Overview

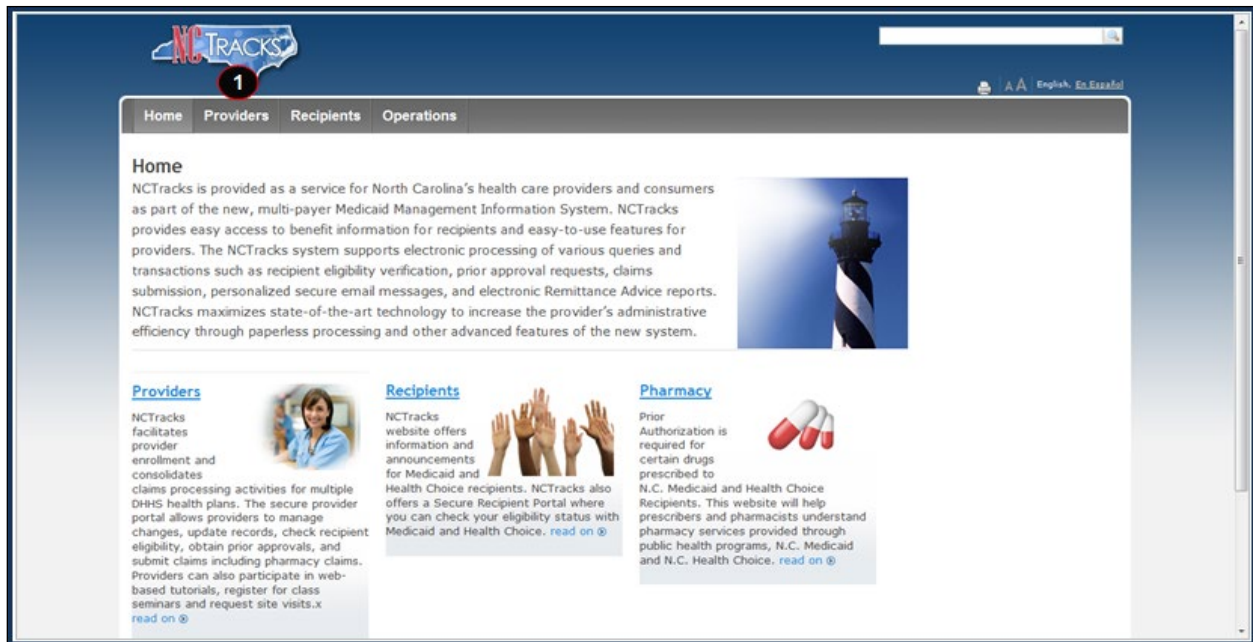
This Job Aid is intended to help providers understand the changes involving Short-Acting Opioid Analgesics and Long-Acting Opioid Analgesics. Existing Prior Approvals (PAs) for short-acting and long-acting narcotic analgesics will continue to be viewable and updateable on the Operations portal. This document discusses the specific differences for PA requirements between the short-acting preferred and non-preferred products and the long-acting preferred and non-preferred products.

PA requests for Opioid Analgesics may still be sent via fax or online via the Provider portal. Submission via telephone is not allowed for Schedule II controlled substances. Patients with terminal cancer or chronic pain diagnosis as the result of cancer will remain exempt from prior approval.

In August 2017, the current maximum daily dose of 750 mg/day of morphine (or similar morphine equivalent) will be reduced to 90 mg/day of morphine (or similar morphine equivalent) dose in the system. The PA High Dose Indicator will default to a value of 'No' (unchecked), which means the patient is not permitted to receive more than 90 mg morphine or equivalent dose. The PA High Dose Indicator will automatically be set to 'Yes' (checked) when the patient has a recent cancer diagnosis.

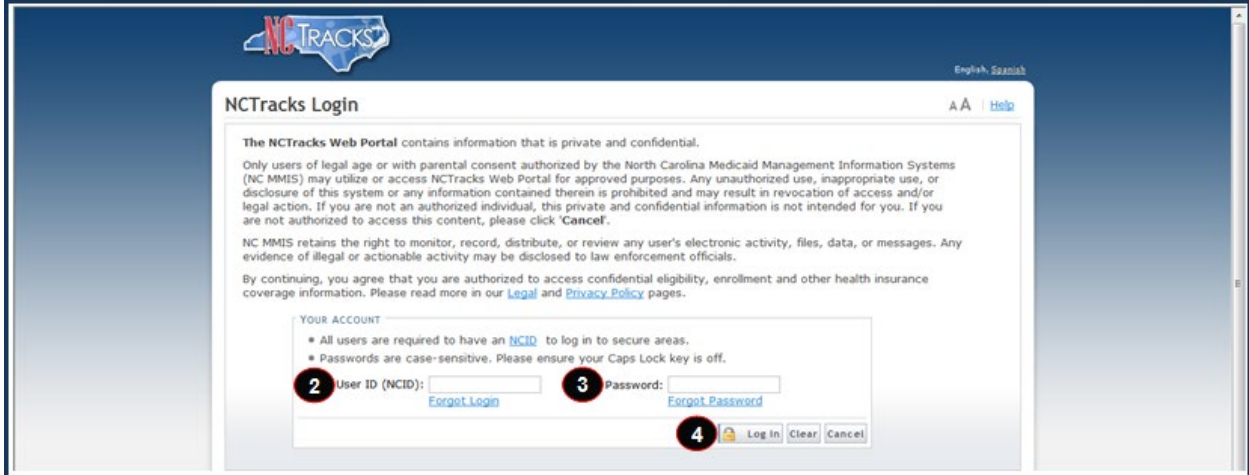
Log In to the Provider Portal

The public NCTracks home page displays before you log in to the system.



To log in to the secure NCTracks Provider portal, complete the following steps.

Step	Action
1	Select the Providers tab. The Public Provider screen displays.

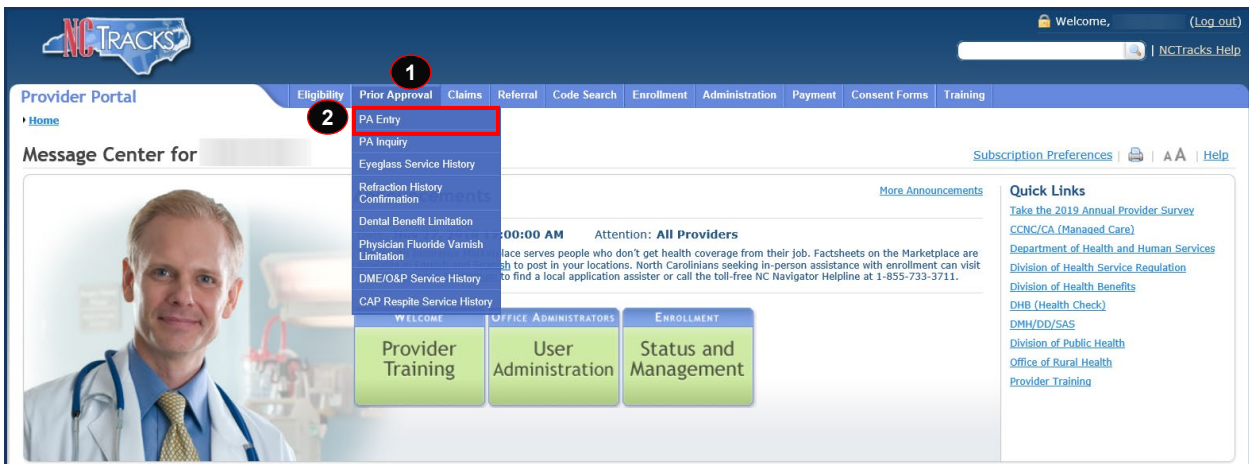


Step	Action
2	User ID (NCID): Enter your NCID.
3	Password: Enter your Password.
4	Select the Log In button.

Requesting a Prior Approval

A Prior Approval is not required for pharmacy claims that bill less than a 15-day supply when the drug is a preferred opioid analgesic (long-acting or short-acting). Claims for preferred opioid analgesics (long-acting or short-acting) will bypass the PA requirement when the exemption is met and a PA is not found for the claim.

Note: If a PA is available, it will be used.



Step	Action
1	Select the Prior Approval menu.
2	Select PA Entry to request a new Prior Approval.

Prior Approval Request – Prior Approval Request Type

The Prior Approval Request page allows authorized external users (i.e., providers) to select the Payer and the Prior Approval Type for the Prior Approval being entered.

Step	Action
1	Select the appropriate radio button under Please select a Payer . Note: To continue working with a previously saved draft, select the Draft Name hyperlink.
2	Select the Health Plan from the drop-down menu. Select NCXIX for Medicaid or NCCXI for North Carolina Health Choice (NCHC).

Provider Portal
 Home > Prior Approval Request

Prior Approval Request
 * Indicates a required field

PRIOR APPROVAL REQUEST TYPE

Record Type	Record Type
Remove	Draft
Remove	Draft
Remove	Draft
Remove	Draft
Remove	Draft

* Please select a Payer:
 DHB DPH

* Health Plan:
 3 * PA Type:
 4 * Drug Type:
 Choose

Site	Draft Name	Last Updated	Added
		1/17/2019 11:05 AM	1/17/2019 11:05 AM
		8/8/2019 1:30 PM	8/8/2019 1:30 PM
		8/13/2020 10:00 AM	8/13/2020 10:00 AM
		10/22/2020 10:04 AM	10/22/2020 10:04 AM
		11/11/2020 10:00 AM	11/11/2020 10:00 AM

Submit 5

Step	Action
3	Select Pharmacy from the PA Type drop-down menu.
4	Select the drug type from the Drug Type drop-down menu.
5	Select the Submit button.

Prior Approval Request – Long-Acting Opioid Analgesics – Preferred LONG-ACTING PREFERRED OPIOID ANALGESICS

- The beneficiary shall have a diagnosis of chronic pain syndrome of at least 4 weeks duration.
- Prior approval is required for total daily doses greater than the allowed maximums. Refer to [Appendix A, Morphine Equivalency Values](#) to view the list of maximum daily dosages for long-acting opioid analgesics.
- Prior approval is required for beneficiaries who have not tried a short-acting opioid in the past 45 days before trying a long-acting opioid regardless of dose or days' supply. Prior approval requests should include the reason that the beneficiary has not used or cannot use a short-acting opioid first.
- Prior approval is required for greater than a 14-day supply.
- Prior approval requests should include the beneficiary's diagnosis and reason for exceeding limits.
- Prior approval requests may be approved for up to 12 months.

The Header tab of the page allows an external user (i.e., provider) to enter Prior Approval common header information.

Provider Portal | Eligibility | Prior Approval | Claims | Referral | Code Search | Enrollment | Administration | Payment | Trading Partner | Consent Forms

Home > Prior Approval Request

Prior Approval Request

* indicates a required field

Legend

BASE INFORMATION

1 * Account Information: [dropdown]

2 * Group: [dropdown]

3 * NPI / Atypical ID: [dropdown]

Header Information | Detail Information | Attachments

Payer: DHB | PA Type: PHARMACY | Drug Class: OPIOID L

RECIPIENT

4 * Recipient ID: [input]

Last Name: [input] | First Name: [input]

Address1: [input] | State: [input] | ZIP Code: [input]

Address2: [input] | City: [input] | Date of Birth: [input]

Gender: [input]

5 Confirm

PRESCRIBER

Last Name: [input] | First Name: [input]

Address1: [input] | State: [input] | ZIP Code: [input]

Address2: [input] | City: [input] | Phone: [input] | Fax: [input]

Next >> | Submit

Step	Action
1	Select the NCID from the Account Information drop-down menu.
2	Select the Group ID from the Group drop-down menu.
3	Select the NPI/Atypical ID from the NPI/Atypical ID drop-down menu. Note: The prescriber information will populate in the Prescriber section.
4	Enter the recipient's ID in the Recipient ID field.
5	Select the Confirm button.

The recipient's demographics display.

Provider Portal | Eligibility | **Prior Approval** | Claims | Referral | Code Search | Enrollment | Administration | Payment | Trading Partner | Consent Forms

Home > Prior Approval Request

Prior Approval Request

* indicates a required field

Legend

BASE INFORMATION

* Account Information: [dropdown]
 * Group: [dropdown]
 * NPI / Atypical ID: [dropdown]

Header Information | Detail Information | Attachments

Payer: DHB | PA Type: PHARMACY | Drug Class: OPIOID L

RECIPIENT

Recipient Information

* Recipient ID: [input]
 Last Name: [input] | First Name: [input]
 Address1: [input]
 Address2: [input]
 City: [input] | State: [input] | ZIP Code: [input]
 Gender: [input] | Date of Birth: [input]

[Confirm]

PRESCRIBER

Last Name: [input] | First Name: [input]
 Address1: [input]
 Address2: [input]
 City: [input] | State: [input] | ZIP Code: [input]
 Phone: [input] | Fax: [input]

6 Next Submit

Request Last Updated:

Step	Action
6	Verify the information and select the Next button.

Diagnosis of Malignant Cancer or Pain Due to Neoplasm

The Detail tab of the page allows an external user (i.e., provider) to enter prior approval detail information.

Step	Action
1	Enter an amount in the Quantity Per 30 Days field.
2	The High Dose Indicator cannot be edited on the Provider portal. The default value is No (unchecked). The value will be systematically updated to Yes (checked) when the response to ' Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ' is Yes .
3	Select the number of days from the Length of Therapy drop-down menu.
4	Answer the question: Is it a request for a non-preferred drug?
5	Select a drug from the Drug Name drop-down menu.
6	Answer the question: Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? Note: When the response is Yes , the remaining questions are not displayed and the PA is approved with the PA High Dose Indicator set to Yes (checked).
7	Select the checkbox to certify the information provided is accurate.

Step	Action
8	Enter your PIN in the Please validate your signature PIN field.
9	Select the Verify button.
10	Select the Next button.

No Diagnosis of Malignant Cancer or Pain Due to Neoplasm

NC TRACKS Welcome, (Log out) | NCTracks Help

Provider Portal | Eligibility | **Prior Approval** | Claims | Referral | Code Search | Enrollment | Administration | Payment | Trading Partner | Consent Forms

Home > Prior Approval Request

Prior Approval Request

* indicates a required field

Legend

BASE INFORMATION

* Account Information: [dropdown]
* Group: [dropdown] * NPI / Atypical ID: [dropdown]

Header Information | **Detail Information** | Attachments

Payer: DHB PA Type: PHARMACY Drug Class: OPIOID L

DETAIL INFORMATION

1 * Quantity Per 30 Days: [input] 3 High Dose Indicator
2 * Length of Therapy: Choose [dropdown] Total Quantity Requested: 0

Clinical Info - Opioid Analgesics Long

4 * Is it a request for a non-preferred drug?
 Yes No

Preferred

5 * Drug Name: Choose [dropdown]

6 * Does the patient have a diagnosis of malignant cancer or pain due to neoplasm?
 Yes No

Cancer or Neoplasm

7 A * Does the beneficiary have a diagnosis of chronic pain syndrome of at least four (4) weeks duration?
 Yes No

B * HIGH DOSE PA REQUEST: Is the requested daily dose in combination with other concurrent opioids less than or equal to 90mg of morphine or an equivalent dose?
 Yes No

Daily Dose Exceeded

i * Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits [input]
ii * Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose [input]

C * Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
 Yes No

Initial Auth

D * Has the beneficiary tried a short-acting opioid analgesic in the past 45 days?
 Yes No

i * Please explain [input]

E * Has the prescriber reviewed and is adhering to the NC Medical Board statement on the use of controlled substances for the treatment of pain?
 Yes No

F * Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate?
 Yes No

G * Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System?
 Yes No

H * Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain?
 Yes No

8 I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

9 * Please validate your signature PIN: [input] [Verify] 10

11 [Next] [Submit]

Request Last Updated: [input] [Save Draft] [Clear Page] [Cancel Request]

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NC Department of Health and Human Services | CSRA TRANSCEND

Step	Action
1	Enter the Quantity Per 30 Days .
2	Select the number of days from the Length of Therapy drop-down menu.
3	The High Dose Indicator cannot be edited on the Provider portal. The default value is No (unchecked). The value will be systematically updated to Yes (checked) when the response to ' Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ' is Yes .
4	Answer the question: Is it a request for a non-preferred drug?
5	Select a drug from the Drug Name drop-down menu.
6	Answer the question: Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? Note: When the response is No , the remaining questions are displayed.
7	<p>The following questions are required when the response to 'Does the patient have a diagnosis of malignant cancer or pain due to neoplasm?' is No.</p> <ul style="list-style-type: none"> A. Does the beneficiary have a diagnosis of chronic pain syndrome of at least four (4) weeks duration? B. HIGH DOSE PA REQUEST: Is the requested daily dose less than or equal to 90mg of morphine or an equivalent dose? Note: The following questions are required when the response to 'Is the requested daily dose less than or equal to 90mg of morphine or an equivalent dose?' is No. <ul style="list-style-type: none"> i. Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits. ii. Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose. C. Is this an initial authorization? Select Yes for an initial authorization. Select No for a reauthorization request. Note: Supporting documentation is required when the response to 'Is this an initial authorization?' is No. D. Has the beneficiary tried a short-acting opioid analgesic in the past 45 days? Note: The following explanation is required when the response to 'Has the beneficiary tried a short-acting opioid analgesic in the past 45 days?' is No. <ul style="list-style-type: none"> i. Please explain. E. Has the prescriber reviewed and is adhering to the NC Medical Board statement on the use of controlled substances for the treatment of pain? F. Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d)

Step	Action
	<p>periodic review, and (e) consultation with specialists in various treatment modalities as appropriate?</p> <p>G. Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System?</p> <p>H. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain?</p>
8	Select the checkbox to certify the information provided is accurate.
9	Enter your PIN in the Please validate your signature PIN field.
10	Select the Verify button.
11	Select the Next button.

Prior Approval Request – Long-Acting Opioid Analgesics – Non-Preferred

LONG-ACTING NON-PREFERRED OPIOID ANALGESICS

- The beneficiary shall have a diagnosis of chronic pain syndrome of at least 4 weeks duration.
- Prior approval is required for all non-preferred long-acting opioids.
- Prior approval requests should include the beneficiary's diagnosis and reason for exceeding limits.
- Prior approval requests may be approved for up to 12 months.
- The beneficiary must have a documented failure within the past year of two preferred opioid analgesics at a dose equivalent to the dose of the product being prescribed or a known documented contraindication to one or more of the preferred ingredients (i.e., dye).

The Header tab of the page allows an external user (i.e., provider) to enter Prior Approval common header information.

Provider Portal | Eligibility | **Prior Approval** | Claims | Referral | Code Search | Enrollment | Administration | Payment | Trading Partner | Consent Forms

Home > Prior Approval Request

Prior Approval Request

* indicates a required field

Legend

BASE INFORMATION

1 * Account Information: [dropdown]

2 * Group: [dropdown]

3 * NPI / Atypical ID: [dropdown]

Header Information | Detail Information | Attachments

Payer: DHB | PA Type: PHARMACY | Drug Class: OPIOID L

RECIPIENT

4 * Recipient ID: [input]

Last Name: [input] | First Name: [input]

Address1: [input] | State: [input] | ZIP Code: [input]

Address2: [input] | City: [input] | Date of Birth: [input]

Gender: [input]

5 Confirm

PRESCRIBER

Last Name: [input] | First Name: [input]

Address1: [input] | State: [input] | ZIP Code: [input]

Address2: [input] | City: [input] | Phone: [input] | Fax: [input]

Next >> | Submit

Step	Action
1	Select the NCID from the Account Information drop-down menu.
2	Select the Group ID from the Group drop-down menu.
3	Select the NPI/Atypical ID from the NPI/Atypical ID drop-down menu. Note: The prescriber information will populate in the Prescriber section.
4	Enter the recipient's ID in the Recipient ID field.
5	Select the Confirm button.

The recipient's demographics display.

Provider Portal | Eligibility | **Prior Approval** | Claims | Referral | Code Search | Enrollment | Administration | Payment | Trading Partner | Consent Forms

Home > Prior Approval Request

Prior Approval Request

* indicates a required field

Legend

BASE INFORMATION

* Account Information: [dropdown]
 * Group: [dropdown]
 * NPI / Atypical ID: [dropdown]

Header Information | Detail Information | Attachments

Payer: DHB PA Type: PHARMACY Drug Class: OPIOID L

RECIPIENT

Recipient Information

* Recipient ID: [input]
 Last Name: [input] First Name: [input]
 Address1: [input]
 Address2: [input]
 City: [input] State: [input] ZIP Code: [input]
 Gender: [input] Date of Birth: [input]

[Confirm]

PRESCRIBER

Last Name: [input] First Name: [input]
 Address1: [input]
 Address2: [input]
 City: [input] State: [input] ZIP Code: [input]
 Phone: [input] Fax: [input]

6 Next Submit

Request Last Updated:

Step	Action
6	Verify the information and select the Next button.

Diagnosis of Malignant Cancer or Pain Due to Neoplasm

The Detail tab of the page allows an external user (i.e., provider) to enter prior approval detail information.

Step	Action
1	Enter an amount in the Quantity Per 30 Days field.
2	The High Dose Indicator cannot be edited on the Provider portal. The default value is No (unchecked). The value will be systematically updated to Yes (checked) when the response to ' Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ' is Yes .
3	Select the number of days from the Length of Therapy drop-down menu.
4	Answer the question: Is it a request for a non-preferred drug?
5	Select a drug from the Drug Name drop-down menu.
6	Answer the question: Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? Note: When the response is Yes , the remaining questions are not displayed and the PA is approved with the PA High Dose Indicator set to Yes (checked).
7	Select the checkbox to certify the information provided is accurate.
8	Enter your PIN in the Please validate your signature PIN field.
9	Select the Verify button.
10	Select the Next button.

No Diagnosis of Malignant Cancer or Pain Due to Neoplasm

The Detail tab of the page allows an external user (i.e., provider) to enter prior approval detail information.

Step	Action
1	Enter the Quantity Per 30 Days .
2	The High Dose Indicator cannot be edited on the Provider portal. The default value is No (unchecked). The value will be systematically updated to Yes (checked) when the response to ' Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ' is Yes .
3	Select the number of days from the Length of Therapy drop-down menu.
4	Answer the question: Is it a request for a non-preferred drug?
5	Select a drug from the Drug Name drop-down menu.
6	Answer the question: Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? Note: When the response is No , the remaining questions are displayed.
7	The following questions are required when the response to ' Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ' is No . A. Does the beneficiary have a diagnosis of chronic pain syndrome of at least four (4) weeks duration? HIGH DOSE PA REQUEST: Is the requested daily dose in combination with other concurrent opioids less than or equal to 90mg of morphine or an equivalent dose?

Step	Action
	<p>i. Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits.</p> <p>ii. Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose.</p>

B * HIGH DOSE PA REQUEST: Is the requested daily dose in combination with other concurrent opioids less than or equal to 90mg of morphine or an equivalent dose?
 Yes No

Daily Dose Exceeded

i * Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits

ii * Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose

C * Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
 Yes No

D * Has the prescriber reviewed and is adhering to the NC Medical Board statement on the use of controlled substances for the treatment of pain?
 Yes No

E * Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate?
 Yes No

F * Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System?
 Yes No

G * Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain?
 Yes No

H * Does the patient have a documented history within the past year of two preferred long-acting Opioid Analgesics at a dose equal to or equivalent to the non-preferred long-acting Opioid Analgesic being prescribed?
 Yes No

I * Does the patient have a contraindication or allergy to ingredients in the preferred product?
 Yes No

Non Preferred

J Failed two preferred drugs. If only one drug is available, then failed one preferred drug.

i * (Failed) Preferred Drug 1

ii * (Failed) Preferred Drug 2

Step	Action
	<p>Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.</p> <p>B. Has the prescriber reviewed and is adhering to the NC Medical Board statement on the use of controlled substances for the treatment of pain?</p> <p>C. Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate?</p> <p>D. Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System?</p> <p>E. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain?</p> <p>F. Does the patient have a documented history within the past year of two preferred long-acting Opioid Analgesics at a dose equal to or equivalent to the non-preferred long-acting Opioid Analgesic being prescribed?</p>

Step	Action
	<p>G. Does the patient have a contraindication or allergy to ingredients in the preferred product?</p> <p>H. Failed two preferred drugs. If only one drug is available, then failed one preferred drug.</p> <p>i. (Failed) Preferred Drug 1: Required when 'Failed two preferred drugs. If only one drug is available, then failed one preferred drug' is checked.</p> <p>ii. (Failed) Preferred Drug 2: Required when 'Failed two preferred drugs. If only one drug is available, then failed one preferred drug' is checked</p>

Justification for non-preferred drug request

K Allergic reaction

Drug-to-drug Interaction

i * Please describe reaction

L Previous episode of an unacceptable side effect or therapeutic failure.

i * Please provide clinical information

M Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs.

i * Please provide clinical information

N Age specific indications.

i * Please give patient age and explain

O Unique clinical indication supported by FDA approval or peer reviewed literature.

i * Please provide clinical information

P Unacceptable clinical risk associated with therapeutic change.

i * Please explain

8 * I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

9 * Please validate your signature PIN: **10**

Request Last Updated:

Step	Action
	<ul style="list-style-type: none"> I. Allergic reaction J. Drug-to-drug interaction <ul style="list-style-type: none"> i. Please describe reaction: K. Previous episode of an unacceptable side effect or therapeutic failure. <ul style="list-style-type: none"> i. Please provide clinical information: L. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. <ul style="list-style-type: none"> i. Please provide clinical information: M. Age specific indications. <ul style="list-style-type: none"> i. Please give patient age and explain: N. Unique clinical indication supported by FDA approval or peer reviewed literature. <ul style="list-style-type: none"> i. Please provide clinical information: O. Unacceptable clinical risk associated with therapeutic change. <ul style="list-style-type: none"> i. Please explain:
8	Select the checkbox to certify the information provided is accurate.
9	Enter your PIN in the Please validate your signature PIN field.
10	Select the Verify button.
11	Select the Next button.

Prior Approval Request – Short-Acting Opioid Analgesics – Preferred

SHORT-ACTING PREFERRED OPIOID ANALGESICS

- Prior approval is required for total daily doses greater than the allowed maximums. Refer to [Appendix A, Morphine Equivalency Values](#) to view the list of maximum daily dosages for short-acting opioid analgesics.
- Prior approval is required for greater than a 14-day supply.
- Prior approval requests should include the beneficiary’s diagnosis and reason for exceeding dose per day limits and duration (days’ supply) limits.
- Prior approval requests may be approved for up to 6 months.
- Reauthorization prior approval requests for beneficiaries with chronic pain must include documentation as to why the beneficiary needs continued opioid treatment and a current plan of care.

The Header tab of the page allows an external user (i.e., provider) to enter Prior Approval common header information.

Step	Action
1	Select the NCID from the Account Information drop-down menu.
2	Select the Group ID from the Group drop-down menu.
3	Select the NPI/Atypical ID from the NPI/Atypical ID drop-down menu. Note: The prescriber information will populate in the Prescriber section.
4	Enter the recipient’s ID in the Recipient ID field.

Step	Action
5	Select the Confirm button.

The recipient's demographics display.

Step	Action
6	Verify the information and select the Next button.

Diagnosis of Malignant Cancer or Pain Due to Neoplasm

The Detail tab of the page allows an external user (i.e., provider) to enter prior approval detail information.

Step	Action
1	Enter an amount in the Quantity Per 30 Days field.
2	The High Dose Indicator cannot be edited on the Provider portal. The default value is No (unchecked). The value will be systematically updated to Yes (checked) when the response to ' Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ' is Yes .
3	Select the number of days from the Length of Therapy drop-down menu.
4	Answer the questions: Is this request for a schedule II drug?
5	Answer the question: Is it a request for a non-preferred drug?
6	Select a drug from the Drug Name drop-down menu.
7	Answer the question: Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? Note: When the response is Yes , the remaining questions are not displayed and the PA is approved with the PA High Dose Indicator set to Yes (checked).
8	Select the checkbox to certify the information provided is accurate.
9	Enter your PIN in the Please validate your signature PIN field.
10	Select the Verify button.
11	Select the Next button.

No Diagnosis of Malignant Cancer or Pain Due to Neoplasm

Header Information | Detail Information | Attachments

Payer: DHB PA Type: PHARMACY Drug Class: OPIOID S

DETAIL INFORMATION

1 * Quantity Per 30 Days: 2 High Dose Indicator

3 * Length of Therapy: Choose Total Quantity Requested: 0

Clinical Info - Opioid Analgesics Short

4 * Is this request for a schedule II drug?
 Yes No

5 * Is it a request for a non-preferred drug?
 Yes No

Preferred

6 * Drug Name: Choose

7 * Does the patient have a diagnosis of malignant cancer or pain due to neoplasm?
 Yes No

Step	Action
1	Enter an amount in the Quantity Per 30 Days field.
2	The High Dose Indicator cannot be edited on the Provider portal. The default value is No (unchecked). The value will be systematically updated to Yes (checked) when the response to ' Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ' is Yes .
3	Select the number of days from the Length of Therapy drop-down menu.
4	Answer the question: Is this request for a schedule II drug?
5	Answer the question: Is it a request for a non-preferred drug?
6	Select a drug from the Drug Name drop-down menu.
7	Answer the question: Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? Note: When the response is No , the remaining questions are not displayed.

Cancer or Neoplasm

7 A * Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
 Yes No

B * Does the beneficiary have Sickle Cell Disease?
 Yes No

Please provide documentation as to why the beneficiary needs continued opioid treatment and current plan of care. Use the Attachments Tab.

C * HIGH DOSE PA REQUEST: Is the requested daily dose in combination with other concurrent opioids less than or equal to 90mg of morphine or an equivalent dose?
 Yes No

Daily Dose Exceeded

i * Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits

ii * Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose

D * Has the prescriber reviewed and is adhering to the NC Medical Board statement on the use of controlled substances for the treatment of pain?
 Yes No

E * Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate?
 Yes No

F * Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System?
 Yes No

G * Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain?
 Yes No

8 * I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

9 * Please validate your signature PIN: **10**

11

Request Last Updated:

Step	Action
7	<p>The following questions are required when the response to 'Does the patient have a diagnosis of malignant cancer or pain due to neoplasm?' is No.</p> <p>A. Is this an initial authorization? Select Yes for an initial authorization. Select No for a reauthorization request. Note: Supporting documentation is required when the response to 'Is this an initial authorization?' is No.</p> <p>B. Does the beneficiary have Sickle Cell Disease?</p> <p>C. HIGH DOSE PA REQUEST: Is the requested daily dose less than or equal to 90mg of morphine or an equivalent dose? Note: The following questions are required when the response to 'Is the requested daily dose less than or equal to 90mg of morphine or an equivalent dose?' is No.</p> <p>i. Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits:</p> <p>ii. Please provide the duration (days' supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose.</p> <p>D. Has the prescriber reviewed and is adhering to the NC Medical Board statement on the use of controlled substances for the treatment of pain?</p> <p>E. Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b)</p>

Step	Action
	<p>establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate?</p> <p>F. Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System?</p> <p>G. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain?</p>
8	Select the checkbox to certify the information provided is accurate.
9	Enter your PIN in the Please validate your signature PIN field.
10	Select the Verify button.
11	Select the Next button.

Prior Approval Request – Short-Acting Opioid Analgesics – Non-Preferred

SHORT-ACTING NON-PREFERRED OPIOID ANALGESICS

- Prior approval is required for total daily doses greater than the allowed maximums. Refer to [Appendix A, Morphine Equivalency Values](#) to view the list of maximum daily dosages for short-acting opioid analgesics.
- Prior approval is required for greater than a 14-day supply.
- Prior approval requests should include the beneficiary's diagnosis and reason for exceeding dose per day limits and duration (days' supply) limits.
- Reauthorization prior approval requests for beneficiaries with chronic pain must include documentation as to why the beneficiary needs continued opioid treatment and current plan of care.
- Prior approval requests may be approved for up to 6 months.

The beneficiary must have a documented failure within the past year of two preferred opioid analgesics at a dose equivalent to the dose of the product being prescribed or a known documented contraindication to one or more of the preferred ingredients.

The Header tab of the page allows an external user (i.e., provider) to enter Prior Approval common header information.

Provider Portal | Eligibility | **Prior Approval** | Claims | Referral | Code Search | Enrollment | Administration | Payment | Trading Partner | Consent Forms

Home > Prior Approval Request

Prior Approval Request

* indicates a required field

Legend

BASE INFORMATION

1 * Account Information: [dropdown]

2 * Group: [dropdown]

3 * NPI / Atypical ID: [dropdown]

Header Information | Detail Information | Attachments

Payer: DHB | PA Type: PHARMACY | Drug Class: OPIOID S

RECIPIENT

Recipient Information

4 [input field]

Last Name: | First Name: | Address1: | Address2: | City: | State: | ZIP Code: | Date of Birth: | Gender: |

5 Confirm

PRESCRIBER

Last Name: [blurred] | First Name: [blurred] | Address1: [blurred] | Address2: [blurred] | City: [blurred] | State: [blurred] | ZIP Code: [blurred] | Phone: [blurred] | Fax: [blurred]

Next » | Submit

Step	Action
1	Select the NCID from the Account Information drop-down menu.
2	Select the Group ID from the Group drop-down menu.
3	Select the NPI/Atypical ID from the NPI/Atypical ID drop-down menu. Note: The prescriber information will populate in the Prescriber section.
4	Enter the recipient's ID in the Recipient ID field.
5	Select the Confirm button.

The recipient's demographics display.

Prior Approval Request

* indicates a required field

AA | Help

Legend

BASE INFORMATION

* Account Information: [dropdown]

* Group: [dropdown]

* NPI / Atypical ID: [dropdown]

Header Information | Detail Information | Attachments

Payer: DHB | PA Type: PHARMACY | Drug Class: OPIOID S

RECIPIENT

Recipient Information

[dropdown]

Last Name: [text] | First Name: [text]

Address1: [text]

Address2: [text]

City: [text] | State: [dropdown] | ZIP Code: [text]

Gender: [text] | Date of Birth: [text]

6 Confirm

PRESCRIBER

Last Name: [text] | First Name: [text]

Address1: [text]

Address2: [text]

City: [text] | State: [dropdown] | ZIP Code: [text]

Phone: [text] | Fax: [text]

Next » | Submit

Request Last Updated:

Step	Action
6	Verify the information and select the Next button.

Diagnosis of Malignant Cancer or Pain Due to Neoplasm

The Detail tab of the page allows an external user (i.e., provider) to enter prior approval detail information.

Step	Action
1	Enter an amount in the Quantity Per 30 Days field.
2	The High Dose Indicator cannot be edited on the Provider portal. The default value is No (unchecked). The value will be systematically updated to Yes (checked) when the response to ' Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ' is Yes .
3	Select the number of days from the Length of Therapy drop-down menu.
4	Answer the question: Is this request for a schedule II drug?
5	Answer the question: Is it a request for a non-preferred drug?
6	Select a drug from the Drug Name drop-down menu.
7	Answer the question: Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? Note: When the response is Yes , the remaining questions are not displayed and the PA is approved with the PA High Dose Indicator set to Yes (checked).
8	Select the checkbox to certify the information provided is accurate.
9	Enter your PIN in the Please validate your signature PIN field.
10	Select the Verify button.
11	Select the Next button.

No Diagnosis of Malignant Cancer or Pain Due to Neoplasm

Provider Portal | Eligibility | **Prior Approval** | Claims | Referral | Code Search | Enrollment | Administration | Payment | Trading Partner | Consent Forms

Home > Prior Approval Request

Prior Approval Request

* indicates a required field

Legend

BASE INFORMATION

* Account Information: [dropdown]
 * Group: [dropdown]
 * NPI / Atypical ID: [dropdown]

Header Information | **Detail Information** | Attachments

Payer: DHB | PA Type: PHARMACY | Drug Class: OPIOID S

DETAIL INFORMATION

1 * Quantity Per 30 Days: [input]
 2 High Dose Indicator
 3 * Length of Therapy: Choose [dropdown] | Total Quantity Requested: 0

Clinical Info - Opioid Analgesics Short

4 * Is this request for a schedule II drug?
 Yes No

5 * Is it a request for a non-preferred drug?
 Yes No

Non Preferred

6 * Drug Name [dropdown]

7 * Does the patient have a diagnosis of malignant cancer or pain due to neoplasm?
 Yes No

Step	Action
1	Enter an amount in the Quantity Per 30 Days field.
2	The High Dose Indicator cannot be edited on the Provider portal. The default value is No (unchecked). The value will be systematically updated to Yes (checked) when the response to ' Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? ' is Yes .
3	Select the number of days from the Length of Therapy drop-down menu.
4	Answer the question: Is this request for a schedule II drug?
5	Answer the question: Is it a request for a non-preferred drug?
6	Select a drug from the Drug Name drop-down menu.
7	Answer the question: Does the patient have a diagnosis of malignant cancer or pain due to neoplasm? Note: When the response is Yes , the remaining questions are not displayed and the PA is approved with the PA High Dose Indicator set to Yes (checked).

7 **A** * Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
 Yes No

B * Does the beneficiary have Sickle Cell Disease?
 Yes No

Please provide documentation as to why the beneficiary needs continued opioid treatment and current plan of care. Use the Attachments Tab.

C * HIGH DOSE PA REQUEST: Is the requested daily dose in combination with other concurrent opioids less than or equal to 90mg of morphine or an equivalent dose?
 Yes No

Daily Dose Exceeded

i * Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits

ii * Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose

D * Has the prescriber reviewed and is adhering to the NC Medical Board statement on the use of controlled substances for the treatment of pain?
 Yes No

E * Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate?
 Yes No

F * Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System?
 Yes No

G * Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain?
 Yes No

H * Does the patient have a documented history within the past year of two preferred short-acting Opioid Analgesics WITHIN THE SAME PDL GROUP at a dose equal to or equivalent to the non-preferred short-acting Opioid Analgesic being prescribed?
 Yes No

I * Does the patient have a contraindication or allergy to ingredients in the preferred product?
 Yes No

Non Preferred

J Failed two preferred drugs. If only one drug is available, then failed one preferred drug.

i * (Failed) Preferred Drug 1

ii * (Failed) Preferred Drug 2

Justification for non-preferred drug request

K Allergic reaction

L Drug-to-drug interaction

i * Please describe reaction

M Previous episode of an unacceptable side effect or therapeutic failure.

i * Please provide clinical information

N Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs.

i * Please provide clinical information

O Age specific indications.

i * Please give patient age and explain

P Unique clinical indication supported by FDA approval or peer reviewed literature.

i * Please provide clinical information

Q Unacceptable clinical risk associated with therapeutic change.

i * Please explain

8 * I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

9 * Please validate your signature PIN: **10**

« Previous **11** Next »

Request Last Updated:

Step	Action
7	The following questions are required when the response to 'Does the patient have a diagnosis of malignant cancer or pain due to neoplasm?' is No. A. Is this an initial authorization? Select Yes for an initial authorization. Select No for a reauthorization request.

Step	Action
	<p>Note: Supporting documentation is required when the response to ‘Is this an initial authorization?’ is No.</p> <p>B. Does the beneficiary have Sickle Cell Disease?</p> <p>C. HIGH DOSE REQUEST: Is the requested daily dose less than or equal to 90mg of morphine or an equivalent dose?</p> <p>Note: The following questions are required when the response to ‘Is the requested daily dose less than or equal to 90mg of morphine or an equivalent dose?’ is No.</p> <p>i. Please supply the beneficiary’s diagnosis and reason for exceeding dose per day limits:</p> <p>ii. Please provide the duration (days’ supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose.</p> <p>D. Has the prescriber reviewed and is adhering to the NC Medical Board statement on the use of controlled substances for the treatment of pain?</p> <p>E. Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate?</p> <p>F. Has the prescribing physician checked the beneficiary’s utilization of controlled substances on the NC Controlled Substance Reporting System?</p> <p>G. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain?</p> <p>H. Does the patient have a documented history within the past year of two preferred short-acting Opioid Analgesics WITHIN THE SAME PDL GROUP at a dose equal to or equivalent to the non-preferred short-acting Opioid Analgesic being prescribed?</p> <p>I. Does the patient have a contraindication or allergy to ingredients in the preferred product?</p> <p>J. Failed two preferred drugs. If only one drug is available, then failed one preferred drug.</p> <p>i. (Failed) Preferred Drug 1: Required when ‘Failed two preferred drugs. If only one drug is available, then failed one preferred drug’ is checked.</p> <p>ii. (Failed) Preferred Drug 2: Required when ‘Failed two preferred drugs. If only one drug is available, then failed one preferred drug’ is checked.</p>

Step	Action
	<ul style="list-style-type: none"> K. Allergic reaction L. Drug-to-drug interaction <ul style="list-style-type: none"> i. Please describe reaction: M. Previous episode of an unacceptable side effect or therapeutic failure. <ul style="list-style-type: none"> i. Please provide clinical information: N. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. <ul style="list-style-type: none"> i. Please provide clinical information: O. Age specific indications. <ul style="list-style-type: none"> i. Please give patient age and explain: P. Unique clinical indication supported by FDA approval or peer reviewed literature. <ul style="list-style-type: none"> i. Please provide clinical information: Q. Unacceptable clinical risk associated with therapeutic change. <ul style="list-style-type: none"> i.
8	Select the checkbox to certify the information provided is accurate.
9	Enter your PIN in the Please validate your signature PIN field.
10	Select the Verify button.
11	Select the Next button.

Appendix A. Morphine Equivalency Values

Drug	Conversion Factor	Dose Equiv. to 120 mg morphine per day
Buprenorphine (patch)	12.6	67 mcg/hr every 7 days*
Buprenorphine (tab/film)	10	12 mg per day
Butorphanol (nasal)	7	17 mg per day*
Butorphanol (parenteral)	15	8 mg per day
Codeine	0.15	800 mg per day*
Dihydrocodeine	0.1	1200 mg per day*
Fentanyl (buccal/SL/lozenge)	0.13	923 mcg per day
Fentanyl (film/oral spray)	0.18	667 mcg per day
Fentanyl (nasal spray)	0.16	750 mcg per day
Fentanyl (patch)	7.2	50 mcg/hr patch every 3 days
Hydrocodone	1	120 mg per day*
Hydromorphone (oral)	3.75	32 mg per day
Hydromorphone (parenteral)	20	6 mg per day
Levorphanol	11	11 mg per day
Meperidine (oral)	0.1	1200 mg per day*
Meperidine (parenteral)	0.4	300 mg per day
Methadone	4	30 mg per day
Morphine (oral)	1	120 mg per day
Morphine (parenteral)	3	40 mg per day
Oxycodone	1.5	80 mg per day
Oxymorphone	3	40 mg per day
Pentazocine	0.33	363 mg per day*
Tapentadol	0.4	300 mg per day
Tramadol	0.1	1200 mg per day*

***Morphine equivalency values may exceed dosage recommendations. These values do not imply suggested dosing.**

Appendix B. Pharmacy Edit Updates

B.1 EDIT 59060

EDIT NUMBER	59060
EDIT DESCRIPTION	High dose PA is required when daily dose exceeds120MG morphine equivalent
DEFAULT EOB	59060 High dose PA is required when daily dose exceeds120MG morphine equivalent

B.2 EDIT 01099

EDIT NUMBER	01099
EDIT DESCRIPTION	PA REQUIRED
DEFAULT EOB	01722 PHARMACY PA REQUIRED

B.3 EDIT 01100

EDIT NUMBER	01100
EDIT DESCRIPTION	DRUG NOT ON PDL/PHARMACY PA REQUIRED
DEFAULT EOB	01723 DRUG NOT ON PDL. PHARMACY PA REQUIRED

B.4 EDIT 01101

EDIT NUMBER	01101
EDIT DESCRIPTION	PHARM PA LIMITS EXCEEDED
DEFAULT EOB	05308 PRIOR AUTHORIZED UNITS EXCEEDED