



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	
Prior Approval Request – Long-Acting Opioid Analgesics – Preferred	5
Long-Acting Preferred Opioid Analgesics	
Diagnosis of Malignant Cancer or Pain Due to Neoplasm	
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.

North Carolina Medicaid Management

Information System (NCMMIS)

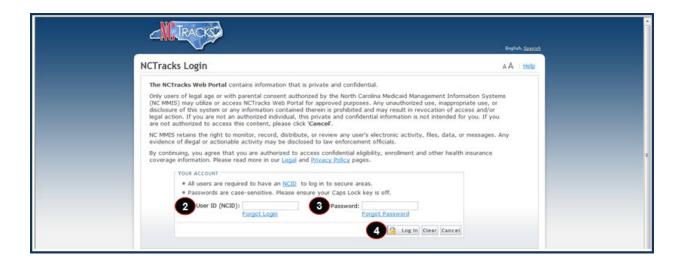


To log in to the secure NCTracks Provider portal, complete the following steps.

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

Job Aid –PRV151 Page 2 of 35



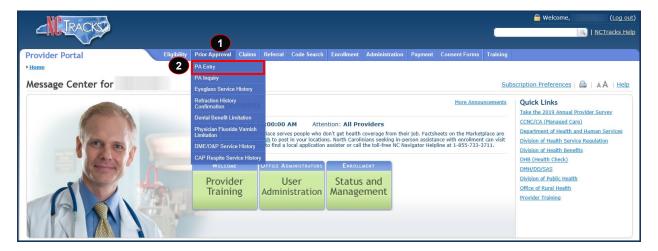


Step	Action
2	User ID (NCID): Enter your NCID.
3	Password: Enter your Password.
4	Select the Log In button.

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.



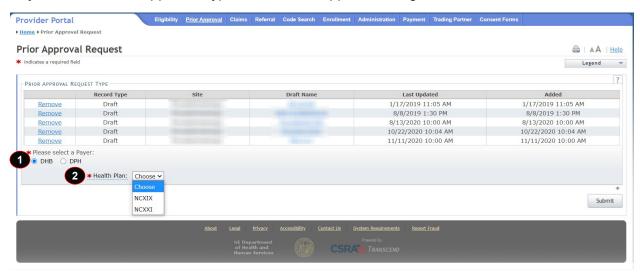
Job Aid –PRV151 Page 3 of 35



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

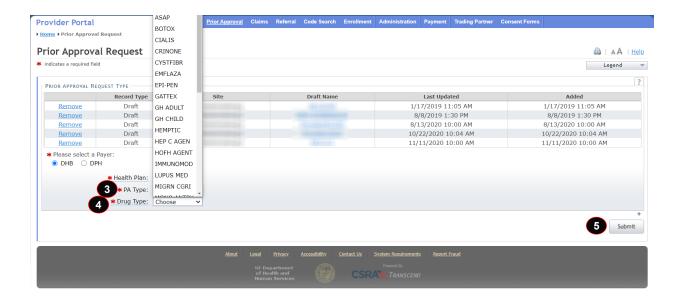
The Prior Approval Request page allows authorized external users (i.e., providers) to select the Payer and the Prior Approval Type for the Prior Approval being entered.



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 NCXXI for North Carolina Health Choice (NCHC).

Job Aid –PRV151 Page 4 of 35





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

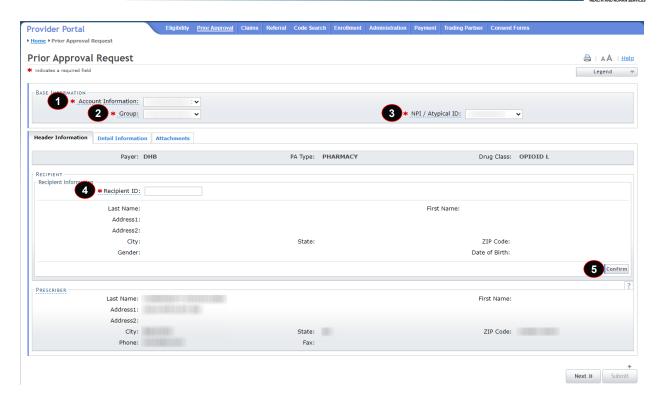
LONG-ACTING PREFERRED OPIOID ANALGESICS

- 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.

Job Aid -PRV151 Page 5 of 35



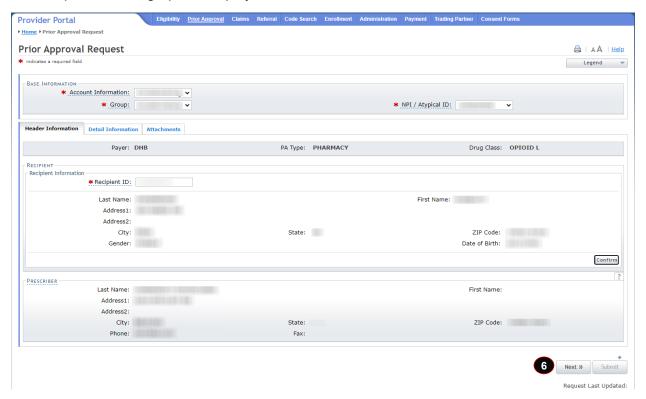


Step	Action
1	Select the NCID from the Account Information drop-down menu.
2	Select the Group ID from the Group drop-down menu.
3	Select the NPI/Atypical ID from the NPI/Atypical ID drop-down menu.
	Note: The prescriber information will populate in the Prescriber section.
4	Enter the recipient's ID in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

Job Aid –PRV151 Page 6 of 35



The recipient's demographics display.



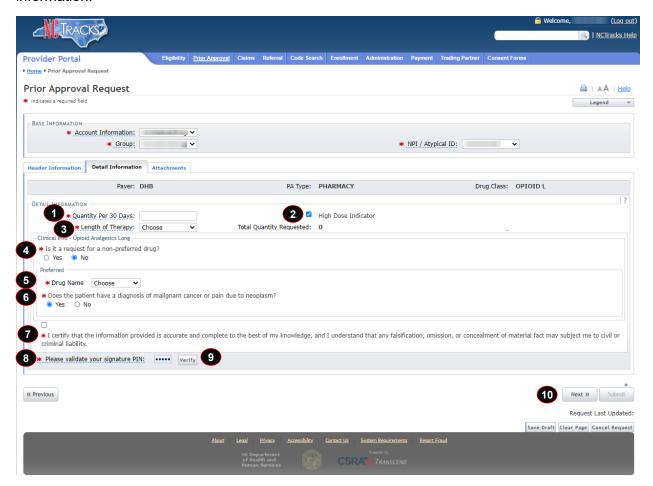
Step	Action
6	Verify the information and select the Next button.

Job Aid –PRV151 Page 7 of 35



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.

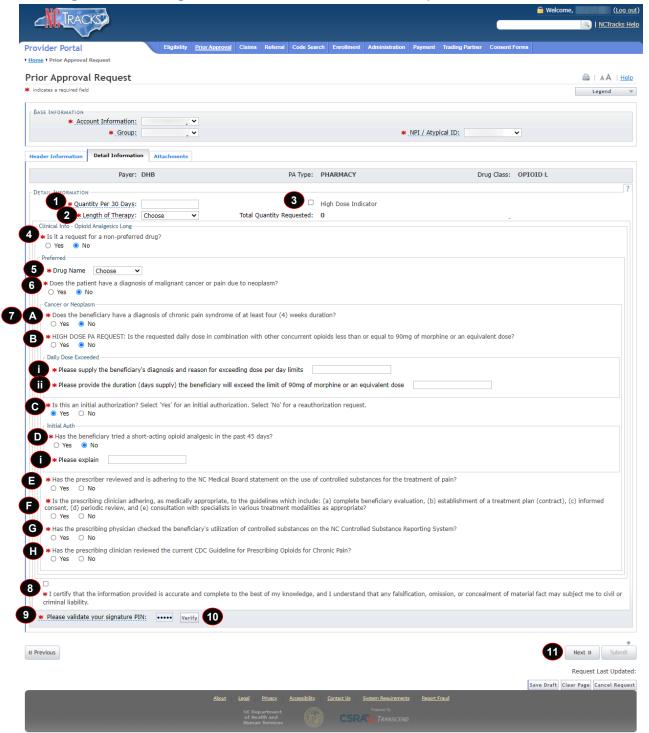
Job Aid –PRV151 Page 8 of 35



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





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
3	is No (unchecked). The value will be systematically updated to Yes (checked) the response to ' Does the patient have a diagnosis of malignant cancer or due to neoplasm? ' is Yes .	when
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 cance pain due to neoplasm?. Note : When the response is No , the remaining questions are displayed.	er or
7	· · · · · · · · · · · · · · · · · · ·	<u></u>
7	 The following questions are required when the response to 'Does the patient I 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? 	nave
	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.	
	 Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits. 	
	 Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose. 	d
	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 than initial authorization?' is No.	nis
	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.	
	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
	periodic review, and (e) consultation with specialists in various treatment modalities as appropriate?
	G. Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System?
	H. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain?
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

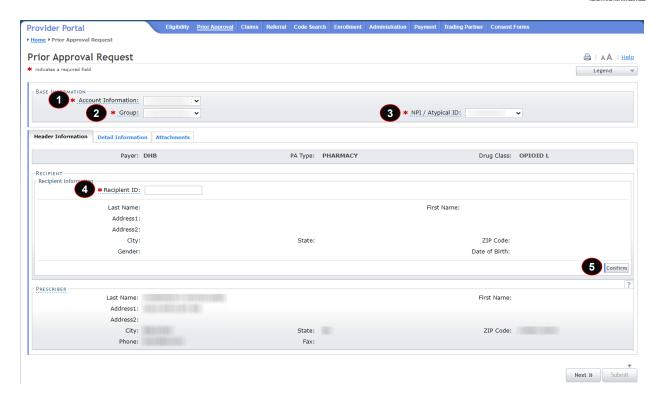
LONG-ACTING NON-PREFERRED OPIOID ANALGESICS

- 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.

Job Aid –PRV151 Page 12 of 35





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.	

Job Aid –PRV151 Page 13 of 35

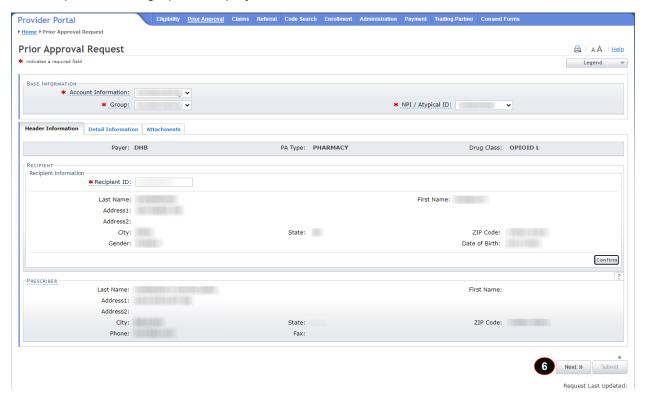




The recipient's demographics display.

North Carolina Medicaid Management

Information System (NCMMIS)



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

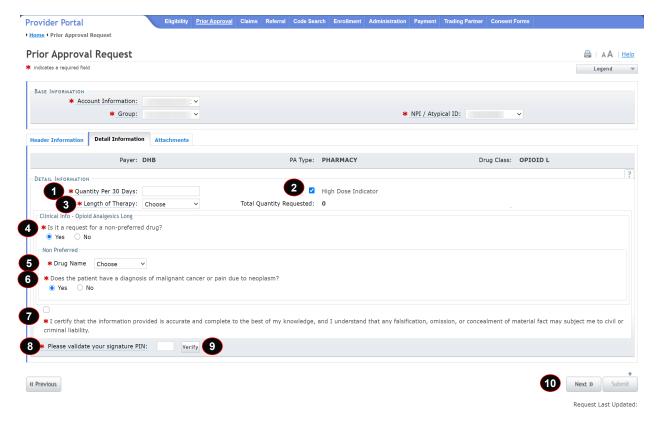
Job Aid -PRV151 Page 14 of 35





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.	

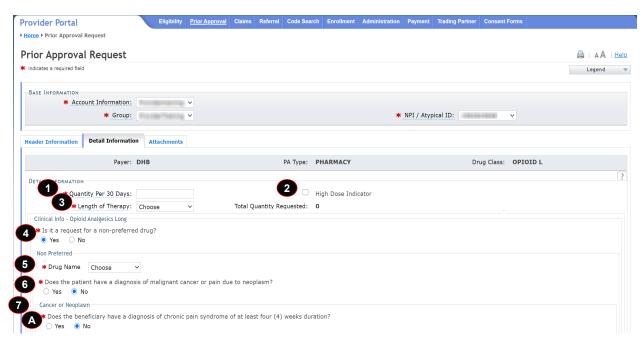
Job Aid –PRV151 Page 15 of 35





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.

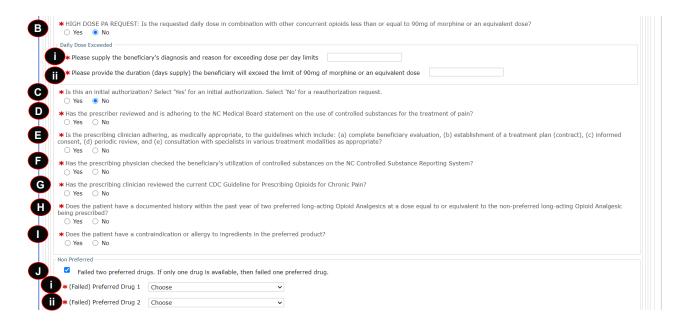


Step	Action		
1	Enter the Quantity Per 30 Days.		
2	The High Dose Indicator cannot be edited on the Provider portal. The default value is No (unchecked). The value will be systematically updated to Yes (checked) when the response to ' Does the patient have a diagnosis of malignant cancer or pain due 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?		

Job Aid –PRV151 Page 16 of 35



Step Action 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.

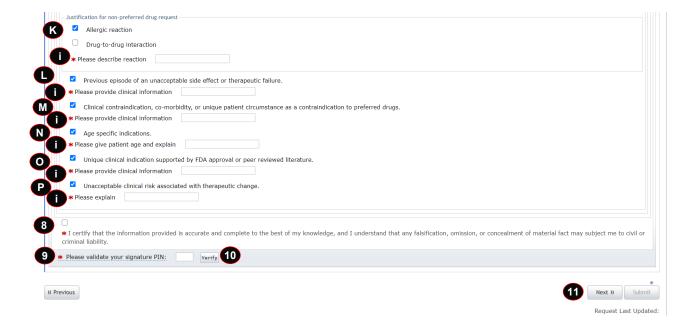


Step	Action	ı
		Is this an initial authorization? Select 'Yes' for an initial authorization. Select 'No' for a reauthorization request.
	B.	Has the prescriber reviewed and is adhering to the NC Medical Board statement on the use of controlled substances for the treatment of pain?
	C.	Is the prescribing 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?
	D.	Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System?
	E.	Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain?
	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?

Job Aid –PRV151 Page 17 of 35



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



Job Aid –PRV151 Page 18 of 35



Step	Action
	I. Allergic reaction
	J. Drug-to-drug interaction
	i. Please describe reaction:
	K. Previous episode of an unacceptable side effect or therapeutic failure.
	i. Please provide clinical information:
	 Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs.
	i. Please provide clinical information:
	M. Age specific indications.
	i. Please give patient age and explain:
	N. Unique clinical indication supported by FDA approval or peer reviewed literature.
	i. Please provide clinical information:
	O. Unacceptable clinical risk associated with therapeutic change.
	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.

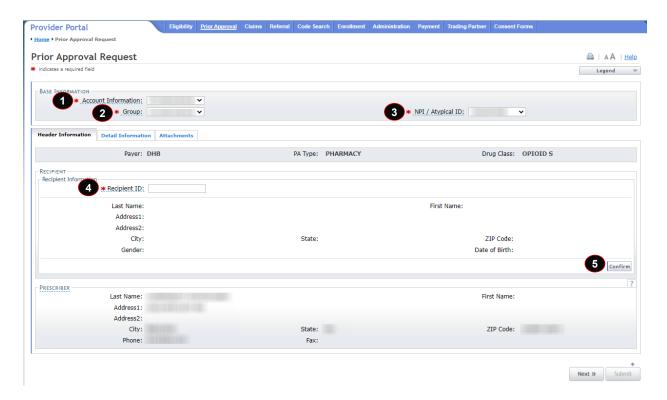


Prior Approval Request - Short-Acting Opioid Analgesics - Preferred

SHORT-ACTING PREFERRED OPIOID ANALGESICS

- Prior approval is required for total daily doses greater than the allowed maximums. Refer
 to <u>Appendix A, Morphine Equivalency Values</u> 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.	

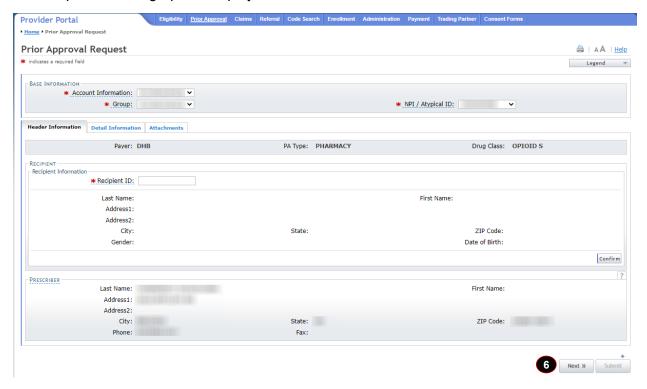
Job Aid –PRV151 Page 20 of 35





Step	Action Select the Confirm button.	
5		

The recipient's demographics display.



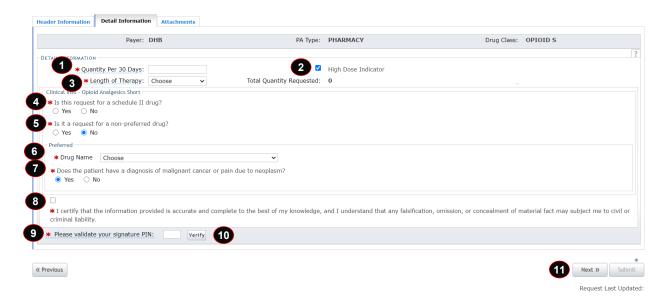
Step	Action
6	Verify the information and select the Next button.

Job Aid –PRV151 Page 21 of 35



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.		

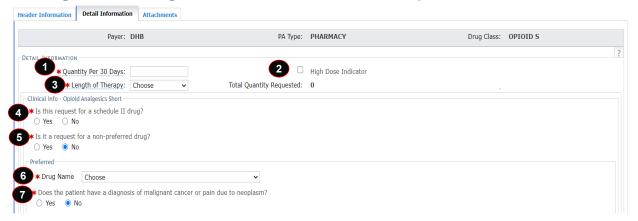
Job Aid –PRV151 Page 22 of 35



North Carolina Medicaid Management Information System (NCMMIS)



No Diagnosis of Malignant Cancer or Pain Due to Neoplasm

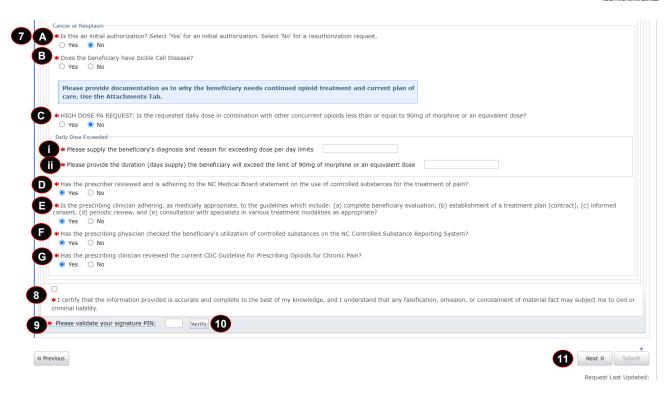


Step	Action	
1	Enter an amount in the Quantity Per 30 Days field.	
2	The High Dose Indicator cannot be edited on the Provider portal. The default value is No (unchecked). The value will be systematically updated to Yes (checked) when the response to ' Does the patient have a diagnosis of malignant cancer 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.	

Job Aid –PRV151 Page 23 of 35







Step	Action	Action	
7	a diag	Illowing questions are required when the response to 'Does the patient have prosis of malignant cancer or pain due to neoplasm?' is No. 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.	
	В.	Does the beneficiary have Sickle Cell Disease?	
	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.	
		 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?	
	E.	Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b)	

Job Aid –PRV151 Page 24 of 35



Step	Action	
	establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate?	
	F. Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System?	
	G. Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain?	
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

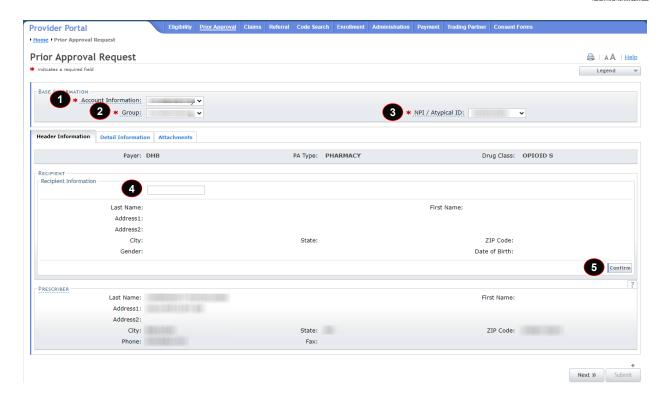
- Prior approval is required for total daily doses greater than the allowed maximums. Refer
 to <u>Appendix A, Morphine Equivalency Values</u> to view the list of maximum daily dosages
 for short-acting opioid analgesics.
- Prior approval is required for greater than a 14-day supply.
- Prior approval 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.

Job Aid –PRV151 Page 25 of 35

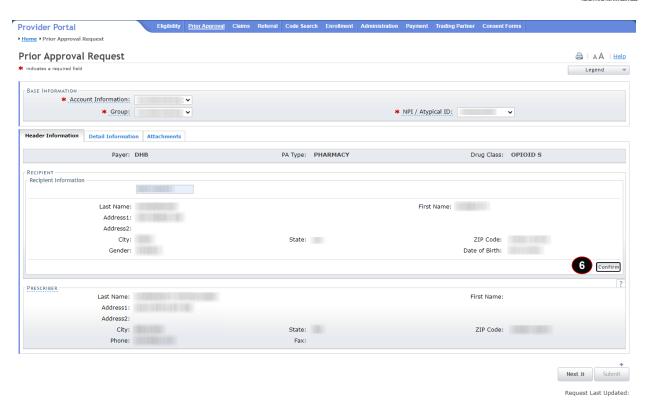




Step	Action	
1	Select the NCID from the Account Information drop-down menu.	
2	Select the Group ID from the Group drop-down menu.	
3	Select the NPI/Atypical ID from the NPI/Atypical ID drop-down menu.	
	Note: The prescriber information will populate in the Prescriber section.	
4	Enter the recipient's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

The recipient's demographics display.





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

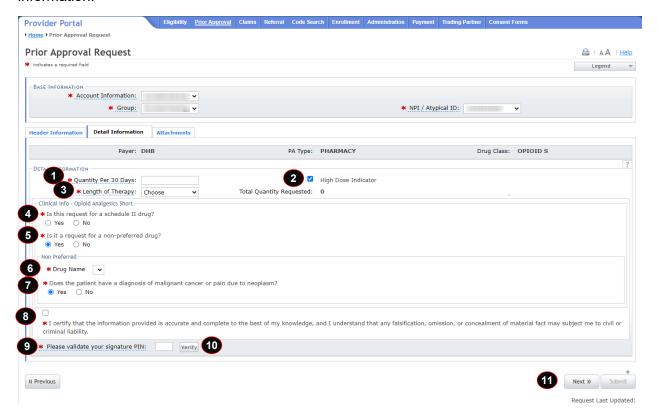
Job Aid –PRV151 Page 27 of 35





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.	

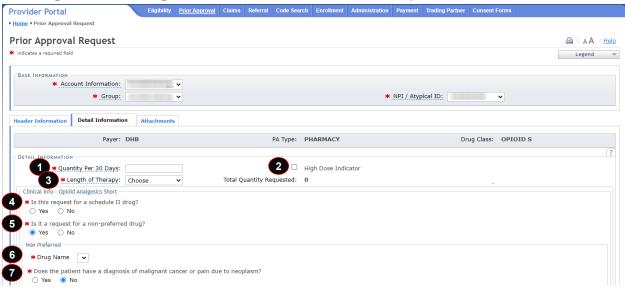
Job Aid –PRV151 Page 28 of 35







No Diagnosis of Malignant Cancer or Pain Due to Neoplasm



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).

Job Aid –PRV151 Page 30 of 35



** It is an initial authorisator bleet "ref for an initial authorisation, select. Tof for a reachhorisation request. Year William Proceedings	Pose the beneficiary have Sides cell Disease? Prices provide documentation as to why the beneficiary needs continued opioid treatment and current plan of core. Des the Altachiments 1941. Prices provide documentation as to why the beneficiary needs continued opioid treatment and current plan of core. Des the Altachiments 1941. Prices Price 8 Republish in the Altachiments 1941. Prices Provide the duration (days supply) the beneficiary diagnosis and reason for exceeding dose per day limits Prices provide the duration (days supply) the beneficiary will acceed the limit of 90mg of morphine or an equivalent dose? Price 8 Republish beneficiary diagnosis and reason for exceeding dose per day limits Prices provide the duration (days supply) the beneficiary will acceed the limit of 90mg of morphine or an equivalent dose Price 9 Republish duration (days supply) the beneficiary will acceed the limit of 90mg of morphine or an equivalent dose Price 9 Republish duration (days supply) the beneficiary will acceed the limit of 90mg of morphine or an equivalent dose Price 10 Republish duration (days supply) the beneficiary will acceed the limit of 90mg of morphine or an equivalent dose Price 10 Republish duration of corrections with specificiary sufficiation of controlled substances for the treatment of plan? Price 10 Republish duration of corrections with specificials in support the morphish duration of controlled substances (Price 10 Republish duration of the price 10	Cancer or Neoplasm	
New Or the hemificiary have Sickle Cell Disease? New Or to New Or the continued opioid treatment and current plan of control to the Attachments Tab.	Please provide documentation as to why the beneficiary needs continued opioid treatment and current plan of current. Use the Altachments Tail. If please provide documentation as to why the beneficiary needs continued opioid treatment and current plan of current. Use the Altachments Tail. If you are in the provide of the provide documentation with other concurrent opioids less than or equal to 90mg of morphine or an equivalent dose? If you are in the provide the duration (days supply) the beneficiary will exceed the limit of 50mg of morphine or an equivalent dose. If you are in the prescriptor reviewed and is addressly asymptotic, to the public limit of 50mg of morphine or an equivalent dose. If you are in the prescriptor reviewed and is addressly asymptotic, to the public limit of 50mg of morphine or an equivalent dose. If you have not the current of public reviews and is addressly asymptotic, to the public limit of 50mg of morphine or an equivalent dose. If you have not the prescriptor reviewed and is addressly asymptotic, to the public limit of 50mg of morphine or an equivalent dose. If you have not the prescriptor reviewed and is addressly asymptotic, to the public limit of the public limits and public lim		Select 'No' for a reauthorization request.
Please provide documentation as to why the beneficiary needs continued opioid treatment and current plan of core. Use the Attachments 120 in 100 cere. Once the Attachment 120 cere. Once the Attachment	Presse provide documentation as to verty the beneficiary needs continued opioid treatment and current plan of care. Use the Attachments Table Presses provide the discriments Table Presses supply the beneficiary's diagnosis and reason for exceeding dose per day limits		
** Intice DOE PA REQUEST: Is the requested daily dose in combination with other concurrent opicids less than or equal to 90mg of morphine or an equivalent dose? ** Into DOE PA REQUEST: Is the requested daily dose in combination with other concurrent opicids less than or equal to 90mg of morphine or an equivalent dose? ** Please provide the duration (days supply) the beneficiary's diagnosis and reason for exceeding dose per day limits ** Please support be beneficiary's diagnosis and reason for exceeding dose per day limits ** Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose. ** Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose. ** Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose. ** Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose. ** Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose. ** Interpretation of the provide provided advantage of the restriction of provided prov	** HIGH COSE PA REQUEST is the requested daily dose in combination with other concurrent opioids less than or equal to 50mg of morphine or an equivalent dose? ** HIGH COSE PA REQUEST is the requested daily dose in combination with other concurrent opioids less than or equal to 50mg of morphine or an equivalent dose? ** HIGH COSE PA REQUEST is the requested daily diagnosis and reason for exceeding dose per day limits ** HIGH COSE PA REQUEST (as the prescriber reviewed and is adhering to the high Cost and the limit of 50mg of morphine or an equivalent dose ** HIGH COSE PA REQUEST (as the prescriber original and is adhering to the high Cost all about attended to the use of controlled substances for the treatment of pain? ** HIGH COSE PA REQUEST (as the prescriber original and high gas a medically appropriate, to the quidelines which include: (2) complete benedicary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) prescribing physician checked the benedicary's unitiation of controlled substances on the NC Controlled Substance Reporting System? ** High Set Prescribing physician checked the benedicary's unitiation of controlled substances on the NC Controlled Substance Reporting System? ** High Be prescribing direction reviewed the current COC Guideline for Prescribing Opioids for Chronic Plain? ** High Be patient have a documented history within the past year of two preferred abort-acting Opioid Analgesics WITHIN THE SAME POL GROUP at a dose equal to or equivalent to the non-preferrable probability of the preferred drugs. ** To the Polic Policy Preferred Grups of Policy Preferred Broad		
**HOH DOSE PA REQUEST: Is the requested daily dose in combination with other concurrent opinide less than or equal to 90mg of morphine or an equivalent dose? New 6 60	**HICH DOSE PA REQUEST: Is the requested daily dose in combination with other concurrent opinids less than or equal to 90mg of morphine or an equivalent dose? Nelses expoyld the beneficiary's diagnosis and reason for exceeding dose per day limits Please provide the duration (days supply) the beneficiary will exceed the limit of 70mg of morphine or an equivalent dose Nelses provide the duration (days supply) the beneficiary will exceed the limit of 70mg of morphine or an equivalent dose Nelses provide the duration (days supply) the beneficiary will exceed the limit of 70mg of morphine or an equivalent dose Nelses provide the duration (days supply) the beneficiary will exceed the limit of 70mg of morphine or an equivalent dose Nelses provide the duration (days supply) the beneficiary will exceed the limit of 70mg of morphine or an equivalent dose Nelses provide the duration (days supply) the beneficiary will exceed the limit of 70mg of morphine or an equivalent dose Nelses provided in the duration of the following provided beneficiary will exceed the limit of 70mg of morphine or an equivalent dose Nelses provided in the following provided the following provided provided to the non-preferred drug. Following provided the following following provided the following following following following fol		continued opioid treatment and current plan of
Daily box becomed Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits Please supply the beneficiary's supply) the beneficiary will exceed the limit of 90 mg of morphine or an equivalent dose I list the prescriber reviewed and is addressing to the IC federical Blood statement on the use of controlled substances for the treatment of pain? I list the prescribing dictions addressing, as mericulary appropriate, to the guidalines which lockeds: (d) complete boxedictary evaluation, (b) setablishment of a treatment plan (contract), (c) informed controlled substances and propriate? I list the prescribing dividence devices, and (d) consultation with epoclatists in various treatment modalities as agargarise? I list the prescribing dividence devices the beneficiary's utilitation of controlled substances on the INC Controlled Substances Reporting System? I list the prescribing dividence reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? I list the prescribing dividence reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? I list the prescribing dividence reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? I list the prescribing dividence reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? I list the prescribing dividence reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain? I list the prescribing dividence device the controlled substances on the INC Controlled Substances Reporting System? I list the prescribing dividence and advanced the beneficiary's utilization of controlled substances on the INC Controlled Substances Reporting System? I list the prescribing dividence and advanced the beneficiary's utilization of controlled substances on the INC Controlled Substances Reporting System? I list the prescribing dividence and advanced the beneficiary's utilization of cont	Dilly Does Decided W Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits W Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits W lease the prescriber reviewed and is adhering to the IX Fledcial Sload statement on the use of controlled substances for the treatment of pain? W less the prescribing direction selecting, as meliculty appropriate, to the quidelines which includer. (g) complete foundations, (b) establishment of a treatment plan (contract), (c) informed controlled substances for the treatment of pain? Visc O No W less the prescribing dividence selected the beneficiary's utilization of controlled substances on the NC Controlled substances Reporting System? Visc O No W less the prescribing dividence selected the beneficiary's utilization of controlled substances on the NC Controlled substances Reporting System? Visc O No W less the prescribing dividence selected the controlled substances on the NC Controlled substances Reporting System? Visc O No W Does the patient have a controlled history within the past year of two preferred short-acting Opiniod Analyses compressible? Visc O No W Does the patient have a controlled interview within the past year of two preferred short-acting Opiniod Analyses compressible? Visc O No Does the patient have a controlled substances on the NC Controlled substances		
# Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits # Ness the prescriber reviewed and is adversing to the hendricary will exceed the limit of 99mg of morphine or an equivalent dose # Ness the prescriber reviewed and is adversing to the Inc Medical Board statement on the use of controlled substances for the treatment of pain' * Yes	# Please supply the beneficiary's diagnosis and reason for exceeding dose per day limits # lease provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose # leas the prescriber reviewed and is adverting to the NC Medical Board statement on the use of controlled substances for the treatment of pain? Yes 10	○ Yes ● No	with other concurrent opioids less than or equal to 90mg of morphine or an equivalent dose?
**Please provide the duration (days supply) the beneficiary will exceed the limit of 90mg of morphine or an equivalent dose **Itas the prescriber reviewed and is adhering to the NC Medical Board statement on the use of controlled substances for the treatment of pain? **Ne	# Has the prescriber reviewed and is adhering to the NC Medical Board statement on the use of controlled substances for the treatment of pain? **Near **N		dose per day limits
** is the prescriber reviewed and is athering to the NC Medical Board statement on the use of controlled substances for the treatment of pain? Yes No ** is the prescribing direidan adhering, as medically appropriate, to the publishines which includes (2) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) preficiel review, and (e) consultation with specialists in various treatment modalities as apportung project for the part of the p	** is the prescriber releved and is adhering to the NC Medical Seard statement on the use of controlled substances for the treatment of pain? Yes No ** is the prescribing efficials adhering, as medically appropriate, to the guidelines which includes (p) complete boundary evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in varieous treatment mediatities as appropriate? Yes No ** It is the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System? Yes No ** It is the prescribing clinician reviewed the current CDC Guideline for Prescribing Opticids for Chronic Pain? Yes No ** It is the prescribing clinician reviewed the current CDC Guideline for Prescribing Opticids for Chronic Pain? Yes No ** Does the patient have a documented history within the past year of two preferred short-acting Opticid Analgesics WITHIN THE SAME PDL GROUP at a dose equal to or equivalent to the non-preferred review of the participant of the preferred product? Yes No ** Does the patient have a contraindication or allergy to ingredients in the preferred product? Yes No ** Does the patient have a contraindication or allergy to ingredients in the preferred drug. Yes No ** Consider Preferred Organs.** Forly one drug is available, then failed one preferred drug. Yes Called Preferred Drug 1 Choose Yes Called Preferred Drug 2 Choose Yes Called Preferred Drug 3 Choose Yes Called Preferred Drug 2 Choose Yes Called Preferred Drug 2 Choose Yes Called Preferred Drug 3 Choose Yes Called Preferred Drug 4 Choose Yes Called Preferred Drug 4 Choose Yes Called Preferred Drug 4 Choose Yes Called Preferred Drug 5 Choose	*Please provide the duration (days supply) the beneficiary will excee-	
** It he 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) prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System? ** Yes	** It he prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b) establishment of a treatment plan (contract), (c) informed concent, (d) periodic review, and (c) consultation with specialists in various treatment modalities as appropriate? ** Yes	*Has the prescriber reviewed and is adhering to the NC Medical Board	statement on the use of controlled substances for the treatment of pain?
** its the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System? Yes No	** It as the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System? Yes	O Yes O No	
Yes	Yes No No No No No No No N	* is trie prescribing cinician aunemig, as medicany appropriate, to trie of consent, (d) periodic review, and (e) consultation with specialists in various Yes O No	
Oves No Non Preferred Oves Woos the patient have a contraindication or allergy to ingredients in the preferred product? Oves No Non Preferred Definition of Preferred Grugs. If only one drug is available, then failed one preferred drug. If (Failed) Preferred Drug 1 Choose Austrication for non-preferred drug regest Allergic reaction Drug-to-drug interaction Please describe reaction Please describe reaction Please provide clinical information Chical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Please provide clinical information Please provide clinical information Drugo drug interaction Please provide clinical information Drugo drugo drugo provide drugo provided in a contraindication supported by FDA approval or peer reviewed literature. Please give patient age and explain Unique clinical information Unique clinical information Unique clinical information Unique drugo drugo drugo provided in a contraindication supported by FDA approval or peer reviewed literature. Unique clinical information Unique drugo drugo drugo provided in a course drugo provided provided provided in a course drugo provided in a course drugo provided in a course drugo provided p	Oves No No Preferred Oves Woos the patient have a contraindication or allergy to ingredients in the preferred product? Oves No No Preferred Oves No Preferred Grugs. If only one drug is available, then failed one preferred drug. If (Failed) Preferred Drug 1 Choose Austrication for non-preferred drug request Allergic reaction Over No Please describe reaction Please describe reaction Please provide clinical information Over No Pl	○ Yes ○ No	ontrolled substances on the NC Controlled Substance Reporting System?
Oves No Non Preferred Oves Woos the patient have a contraindication or allergy to ingredients in the preferred product? Oves No Non Preferred Definition of Preferred Grugs. If only one drug is available, then failed one preferred drug. If (Failed) Preferred Drug 1 Choose Austrication for non-preferred drug regest Allergic reaction Drug-to-drug interaction Please describe reaction Please describe reaction Please provide clinical information Chical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Please provide clinical information Please provide clinical information Drugo drug interaction Please provide clinical information Drugo drugo drugo provide drugo provided in a contraindication supported by FDA approval or peer reviewed literature. Please give patient age and explain Unique clinical information Unique clinical information Unique clinical information Unique drugo drugo drugo provided in a contraindication supported by FDA approval or peer reviewed literature. Unique clinical information Unique drugo drugo drugo provided in a course drugo provided provided provided in a course drugo provided in a course drugo provided in a course drugo provided p	Oves No No Preferred Oves Woos the patient have a contraindication or allergy to ingredients in the preferred product? Oves No No Preferred Oves No Preferred Grugs. If only one drug is available, then failed one preferred drug. If (Failed) Preferred Drug 1 Choose Austrication for non-preferred drug request Allergic reaction Over No Please describe reaction Please describe reaction Please provide clinical information Over No Pl	# Has the prescribing clinician reviewed the current CDC Guideline for Pr ○ Yes ○ No	escribing Opiolds for Chronic Pain?
Non Preferred Verify Veri	Non Preferred Vest No Non Preferred drugs. If only one drug is available, then failed one preferred drug. Vest		to preferred short-acting Opioid Analgesics WITHIN THE SAME PDL GROUP at a dose equal to or equivalent to the non-preferre
tion Preferred J Paled two preferred drugs. If only one drug is available, then failed one preferred drug. j ** (Failed) Preferred Drug 1	tion Preferred Preferred Preferred Preferred drugs. If only one drug is available, then failed one preferred drug. Preferred Preferred Drug 1		e preferred product?
Falled two preferred drugs. If only one drug is available, then falled one preferred drug. K (Falled) Preferred Drug 1	Falled two preferred drugs. If only one drug is available, then failed one preferred drug. Kalled Preferred Drug 1		
i (Falled) Preferred Drug 1 Choose i (Falled) Preferred Drug 2 Choose ustification for non-preferred drug request k Allergic reaction i Please describe reaction i Please provide clinical information C Clinical contrainfication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. i Clinical contrainfication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. i Please provide clinical information Age specific indications. i Please provide clinical information u Age specific indications. i Please give patient age and explain u Inique clinical information u Inique	i		
We Falled Preferred Drug 2 Choose Vastification for non-preferred drug request Austification for non-preferred drug request Allergic reaction Drug-to-drug interaction Drug-to-drug interaction Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode clinical information	ii * Please provide clinical information Age specific indications. Age specific indications supported by FDA approval or peer reviewed literature. Age specific indications supported by FDA approval or peer reviewed literature. Age specific indications supported by FDA approval or peer reviewed literature. Age specific indications supported by FDA approval or peer reviewed literature. Age specific indications supported by FDA approval or peer reviewed literature. Age specific indications specific indications supported by FDA approval or peer reviewed literature. Age specific indications		a one preferred arug.
Justification for non-preferred drug request Allergic reaction Drug-to-drug interaction Drug-to-drug interaction Drug-to-drug interaction Drug-to-drug interaction Dru	** Please give patient age and explain Milegic indications or unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Previous episode of an unacceptable side effect or therapeutic rimidure. Previous episode of an unacceptable side effect or therapeutic rimidure. Previous episode of an unacceptable side effect or therapeutic rimidure. Previous episode of an unacceptable side effect or therapeutic rimidure. Previous episode of an unacceptable side effect or therapeutic rimidure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptab	(Failed) Preferred Drug 1 Choose	v
Allergic reaction Drug-to-drug interaction Drug-to-drug interaction Drug-to-drug interaction Previous episode of an unacceptable side effect or therapeutic failure.	Allergic reaction Drug-to-drug interaction Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Wently Please provide clinical information	(Failed) Preferred Drug 2 Choose	v
Drug-to-drug interaction i ** Please describe reaction M	Drug-to-drug interaction i w Please describe reaction W Previous episode of an unacceptable side effect or therapeutic failure. i w Please provide clinical information C Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Please provide clinical information U Age specific indications. N Please give patient age and explain U Unique clinical information U Unique clinical information U Unacceptable clinical information U Hease provide clinical information U age specific information U to the please provide clinical information U to the please provide clinical information U to the please explain V Please explain V 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 charciminal liability. N Please validate your signature PIN: Verity 10	Justification for non-preferred drug request	
i Please describe reaction Previous episode of an unacceptable side effect or therapeutic failure. Previous episode clinical information Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Please provide clinical information Age specific indications. Previous episode clinical information Unique clinical information Unique clinical indication supported by FDA approval or peer reviewed literature. Unique clinical information Unique cli	i ** Please describe reaction Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode clinical information	K □ Allergic reaction	
i Please describe reaction Previous episode of an unacceptable side effect or therapeutic failure. Previous episode clinical information Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Please provide clinical information Age specific indications. Previous episode clinical information Unique clinical information Unique clinical indication supported by FDA approval or peer reviewed literature. Unique clinical information Unique cli	i ** Please describe reaction Previous episode of an unacceptable side effect or therapeutic failure. Previous episode of an unacceptable side effect or therapeutic failure. Previous episode clinical information	✓ Drug-to-drug interaction	
Previous episode of an unacceptable side effect or therapeutic failure. **Please provide clinical information	Previous episode of an unacceptable side effect or therapeutic failure. **Please provide clinical information		
i * Please provide clinical information Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Age specific indications. Please give patient age and explain Unique clinical indication supported by FDA approval or peer reviewed literature. Verify Unacceptable clinical risk associated with therapeutic change. * Please explain * 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 cive criminal liability. Nelease validate your signature PIN: Verify 10	i * Please provide clinical information Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Age specific indications. Please give patient age and explain Unique clinical indication supported by FDA approval or peer reviewed literature. Verify Unacceptable clinical risk associated with therapeutic change. * Please explain * 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 che criminal liability. Nelease validate your signature PIN: Verify Verify 10	* Please describe reaction	
i * Please provide clinical information Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Please provide clinical information Unique clinical indications. Please give patient age and explain Unique clinical indication supported by FDA approval or peer reviewed literature. Unique clinical information Unacceptable clinical risk associated with therapeutic change. Please explain **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 cive criminal liability. **Please validate your signature PIN: Verity 10	i * Please provide clinical information Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Please provide clinical information Age specific indications. Please give patient age and explain Unique clinical indication supported by FDA approval or peer reviewed literature. Unique clinical information Unacceptable clinical risk associated with therapeutic change. Please explain * Please explain * 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 check the criminal liability. Please validate your signature PIN: Verity 10	Previous episode of an unaccentable side effect or therapeutic fail	TITO TO THE TITO THE TITO TO THE TITO TO THE TITO TO THE TITO THE
Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Please provide clinical information	Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drugs. Please provide clinical information	Tremas spisode of all allacespicatic state affect of allecapedia lain	and the second s
Age specific indications. Age specific indications. Please give patient age and explain Unique clinical indication supported by FDA approval or peer reviewed literature. Unique clinical information Unique clinical information Unique clinical information Unacceptable clinical risk associated with therapeutic change. Please explain Nelease explain Nelea	Age specific indications. Age specific indications. Please give patient age and explain Unique clinical indication supported by FDA approval or peer reviewed literature. Unique clinical information Unique clinical information Unique clinical information Unacceptable clinical risk associated with therapeutic change. Please explain Werity Please explain Werity 10 Please validate your signature PIN: Verity Verity Verity		
Age specific indications. ** Please give patient age and explain	Age specific indications.		ince as a contraindication to preferred drugs.
P Please give patient age and explain Unique clinical indication supported by FDA approval or peer reviewed literature. Via Please provide clinical information Unacceptable clinical risk associated with therapeutic change. Verify 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 cive criminal liability. Neplease validate your signature PIN: Verify 10	P Please give patient age and explain Unique clinical indication supported by FDA approval or peer reviewed literature. Values are provide clinical information Unacceptable clinical risk associated with therapeutic change. Verify 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 che criminal liability. Ne Please validate your signature PIN: Verify 10		
Unique clinical indication supported by FDA approval or peer reviewed literature. Where Please provide clinical information Unacceptable clinical risk associated with therapeutic change. Please explain Where Please e	Unique clinical indication supported by FDA approval or peer reviewed literature. We Please provide clinical information	Age specific indications.	
Werify Welease validate your signature PIN: Werify Unique clinical indication supported by FDA approval or peer reviewed literature. Which clinical indication supported by FDA approval or peer reviewed literature. Unacceptable clinical risk associated with therapeutic change. I werify 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 cive criminal liability. Werify Werify 10	Window clinical indication supported by FDA approval or peer reviewed literature. What Please provide clinical information Unacceptable clinical risk associated with therapeutic change. I Please explain * 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 che criminal liability. * Please validate your signature PIN: Verify Verify 10		
Unacceptable clinical risk associated with therapeutic change. We Please explain I we risk associated with therapeutic change. We rease explain 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 cive criminal liability. We risk 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 cive criminal liability.	Unacceptable clinical risk associated with therapeutic change. ** Please explain ** 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 che criminal liability. ** Please validate your signature PIN: ** Verify** ** Please validate your signature PIN: ** Verify** ** Verify** ** Please validate your signature PIN: ** Verify** ** Verify** ** Verify** ** Please validate your signature PIN: ** Verify** ** Verify** ** Please validate your signature PIN: ** Verify** ** Veri	Unique clinical indication supported by FDA approval or peer revie	wed literature.
Whacceptable clinical risk associated with therapeutic change. ** Please explain ** 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 criminal liability. ** Please validate your signature PIN: ** Verify** ** Please validate your signature PIN: ** Verify** ** Verify** ** Verify** ** Please validate your signature PIN: ** Verify** ** Verify** ** Please validate your signature PIN: ** Verify** ** Verify** ** Please validate your signature PIN: ** Verify** ** Verify** ** Please validate your signature PIN: ** Verify** **	Whease explain *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 che criminal liability. **Nowledge** **N		
Please explain P	** Please explain ** 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 circiminal liability. ** Please validate your signature PIN: Verify ** Verify	Unacceptable clinical risk associated with therangutic change.	
*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 civilial liability. 9 **Please validate your signature PIN:	* 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 characteristic in 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 characteristic in 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 characteristic in 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 characteristic in 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 characteristic in 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 characteristic in the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, or concealment of material fact may subject me to characteristic in the information provided is accurate and concealment of material fact may subject me to characteristic in the information provided in the information provided is accurate and concealment of the information provided is accurate and concealment of the information provided is accurate and concealment of the information provided in the information		
*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 civilial liability. 9 **Please validate your signature PIN:	* 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 che criminal liability. 9 * Please validate your signature PIN: Verify 10		
criminal liability. 9 * Please validate your signature PIN: Verify 10	criminal liability. 9 * Please validate your signature PIN: verify 10	8 Leastify that the information assuided in assurate and complete to the	heat of my legulades and I understand that any falsification excessed on a consoling at material fact may subject me to distinct
			леэх от тту клютесьуе, ани 1 unuerstanu that any raishitation, omission, or concealment or material fact may subject me to civ
Meyt 13	11) Next 3)	9 k Please validate your signature PIN: Verify 10	
Nevt to	11) Next 3)		
	10 Next II	// Previous	Most W

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.

Job Aid –PRV151 Page 31 of 35



Step	Action	
- Otep	7.000	Note: Supporting documentation is required when the response to 'Is this
		an initial authorization?' is No.
	В.	Does the beneficiary have Sickle Cell Disease?
	C.	HIGH DOSE 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.
		 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?
	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?
	F.	Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System?
	G.	Has the prescribing clinician reviewed the current CDC Guideline for Prescribing Opioids for Chronic Pain?
	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?
	I.	Does the patient have a contraindication or allergy to ingredients in the preferred product?
	J.	Failed two preferred drugs. If only one drug is available, then failed one preferred drug.
		i. (Failed) Preferred Drug 1: Required when 'Failed two preferred drugs. If only one drug is available, then failed one preferred drug' is checked.
		ii. (Failed) Preferred Drug 2: Required when 'Failed two preferred drugs. If only one drug is available, then failed one preferred drug' is checked.



Step	Action	
	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.	
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

Job Aid –PRV151 Page 35 of 35