PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Hysingla ER (hydrocodone bitartrate extended-release)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Drug product: ☐ Hysingla ER

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must be age 18 or older
2. Must sign an opioid treatment agreement
3. Must be treating chronic pain (pain lasting more than 90 days) that requires daily, around the clock, long-term treatment
   - Hysingla ER is ***not*** covered for acute pain, as needed use, or post-operative pain
4. Must first try and fail* two of the following drugs: morphine sulfate extended-release, fentanyl patch, methadone
   - The requested dose of Hysingla ER cannot exceed the oral morphine equivalent dose (MED) of trialed medications. For example, if the member trialed morphine sulfate ER 15 mg tablets twice daily (30 MED), the requested amount of Hysingla ER cannot exceed 30 MED per day. See the oral MED chart under *Additional Information*.
5. Must first try and fail (unless contraindicated) non-opioid treatment options
6. Must first try and fail* OxyContin

*Failure of an opioid is defined as one of the following:

- True drug allergy (e.g., an allergy involving the immune system) OR
- Drug intolerance defined as an intolerance that is reproducible on subsequent trials with other manufacturers (if applicable) and strengths and is not a common or expected side effect of the medication (e.g., itching, nausea) OR
- Unable to achieve adequate pain control with same MED as requested medication

MED/day limit*:* To combat the national opioid epidemic and to encourage the appropriate use of opioids, members are limited to a total of 120 MED per day. Utilization exceeding 120 MED per day will require a separate prior authorization request to establish medical necessity. Please refer to the Opioid Exception prior authorization form for prior authorization requirements.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 05/2018

Last reviewed 03/2020

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Chronic pain requiring daily, around the clock, long-term treatment

☐ *Other – the patient's condition is:* _____

B. Has an opioid treatment agreement been signed?

☐ Yes. ☐ No. *Rationale:* _____

C. Has the patient tried and failed two of the following: morphine ER, fentanyl patch, or methadone?

☐ Yes (list drug information below) ☐ No. *Rationale*: _____

Drug	Dose	Dates	Outcome

D. What is the reason for failure of the above medications?

☐ True drug allergy; ***Please list allergy*:** _____

☐ Drug intolerance; ***Please list intolerance*:** _____

☐ Have other manufacturers and strengths been attempted? ☐ Yes ☐ No

☐ Failure to achieve adequate pain control

D. Has the patient tried and failed OxyContin?

☐ Yes ☐ No. *Rationale:* _____

E. What is the reason for failure of OxyContin?

☐ True drug allergy; **Please list allergy:** _____

☐ Drug intolerance; **Please list intolerance:** _____

☐ Failure to achieve adequate pain control

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F. Has the patient tried non-opioid treatments (e.g. NSAID's, TCA's, gabapentin)?

☐ Yes (list drug information below) ☐ No. *Rationale*: _____

Drug	Dose	Dates	Outcome

G. Does the requested morphine equivalent dose (MED) exceed the MED of the previously trialed medications?

☐ No. ☐ Yes. *Rationale:* _____

Additional information

Oral Morphine Equivalent Dose (MED) Chart

Drug name	Conversion factor
Hydrocodone	1
Oxycodone	1.5
Methadone	
>0, ≤ 20	4
>20, ≤ 40	8
>40, ≤ 60	10
>60	12
Oxymorphone	3
Hydromorphone	4
Morphine	1
Codeine	0.15
Fentanyl patches	7.2

Example: 25 ug/hr fentanyl patch * 24 hrs = 600 ug/day fentanyl = 60 mg/day oral morphine milligram equivalent. In other words, the conversion factor not accounting for days of use would be 60/25 or 2.4. However, since the fentanyl patch remains in place for 3 days, we have multiplied the conversion factor by 3 (2.4 X 3 = 7.2). In this example, MME/day for ten 25 µg/hr fentanyl patches dispensed for use over 30 days would work out as follows: Example: 25 ug/hr fentanyl patch * (10 patches/30 days)* 7.2 = 60 MME/day.

A more complete reference is available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-March-2015.pdf

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