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

Contents

Overview

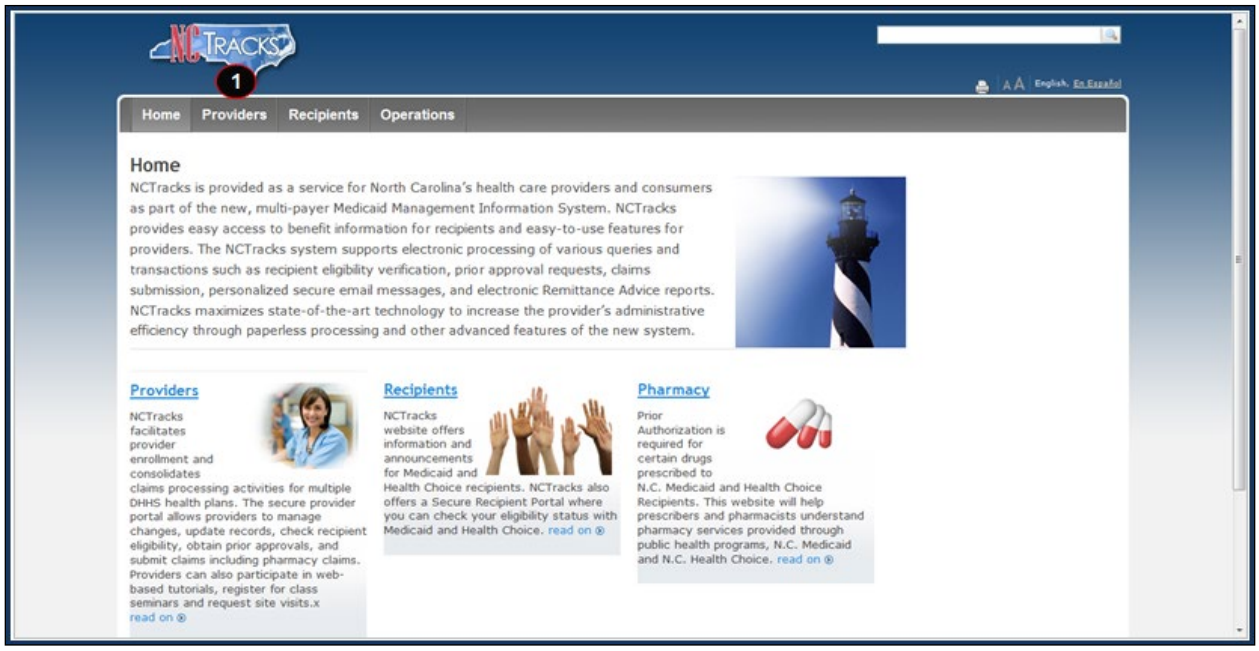
This Job Aid is intended to help providers understand the changes involving Short-Acting Opioid Analgesics and Long-Acting Opioid Analgesics. Existing Prior Approvals (PAs) for short-acting and long-acting narcotic analgesics will continue to be viewable and updateable on the Operations portal. This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

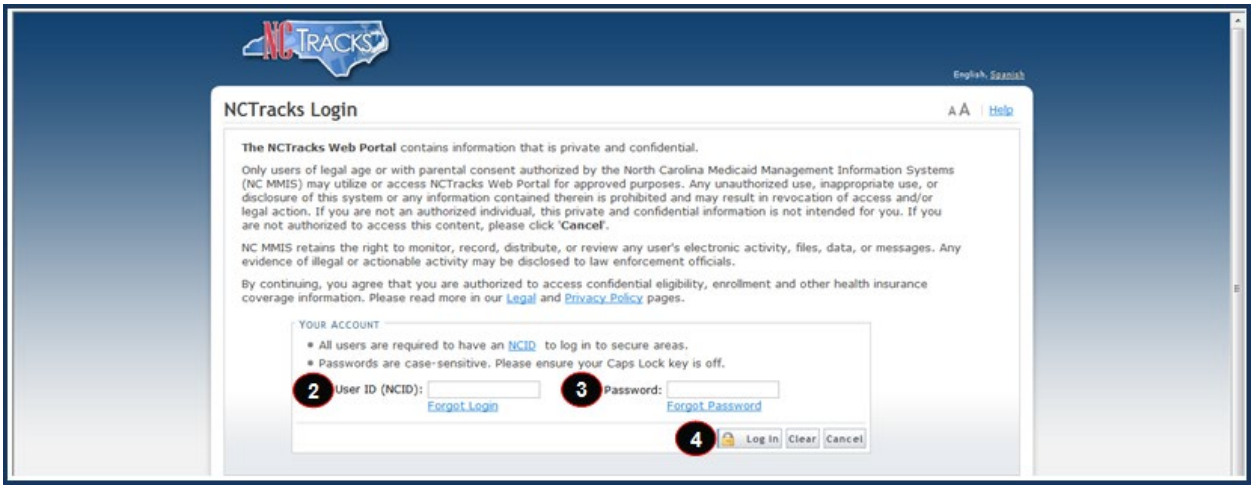
Log In to the Provider Portal

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.

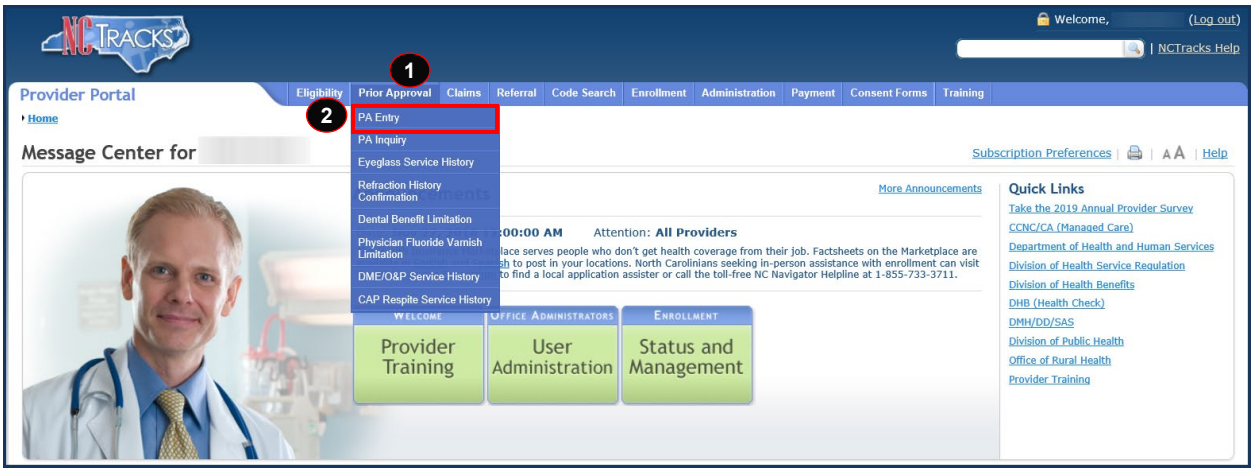


Step	Action
2	**User ID (NCID):** Enter your NCID.
3	**Password:** Enter your Password.
4	Select the **Log In** button.

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.

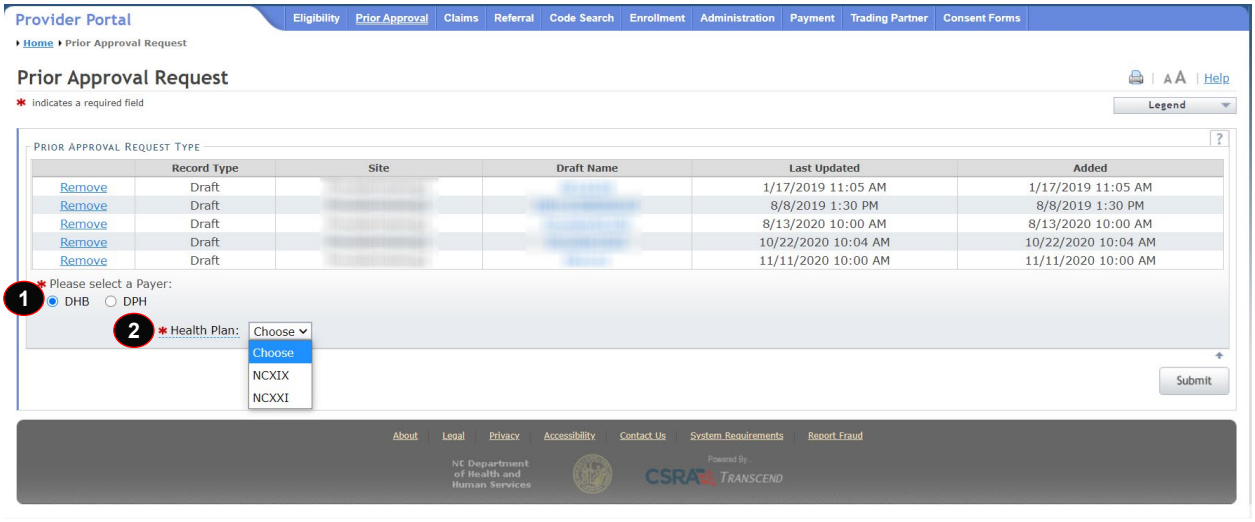
Note: If a PA is available, it will be used.



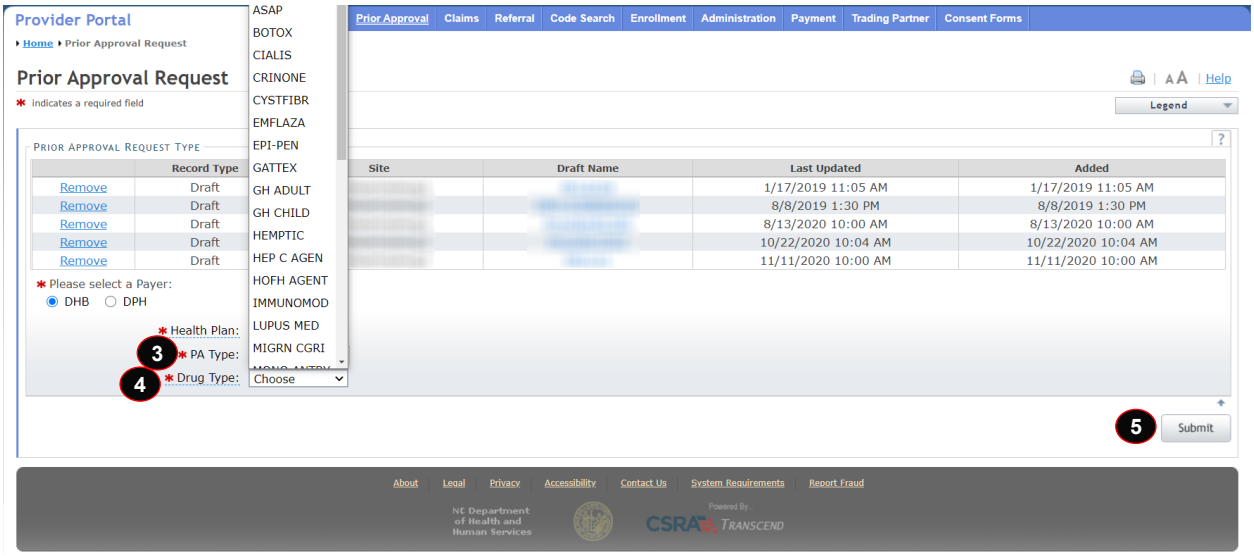
Step	Action
1	Select the **Prior Approval** menu.
2	Select **PA Entry** to request a new Prior Approval.

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 **NCXXI** for North Carolina Health Choice (NCHC).



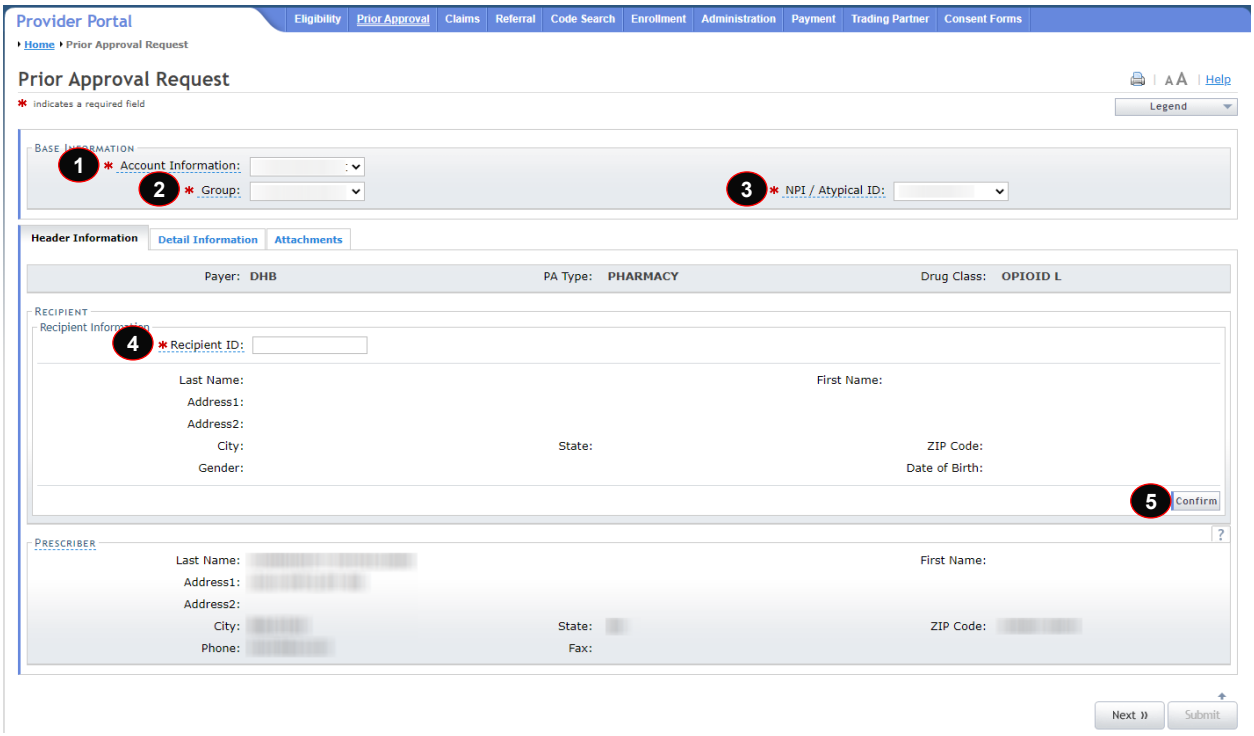
Step	Action
3	Select **Pharmacy** from the **PA Type** drop-down menu.
4	Select the drug type from the **Drug Type** drop-down menu.
5	Select the **Submit** button.

Prior Approval Request – Long-Acting Opioid Analgesics – Preferred

LONG-ACTING PREFERRED OPIOID ANALGESICS

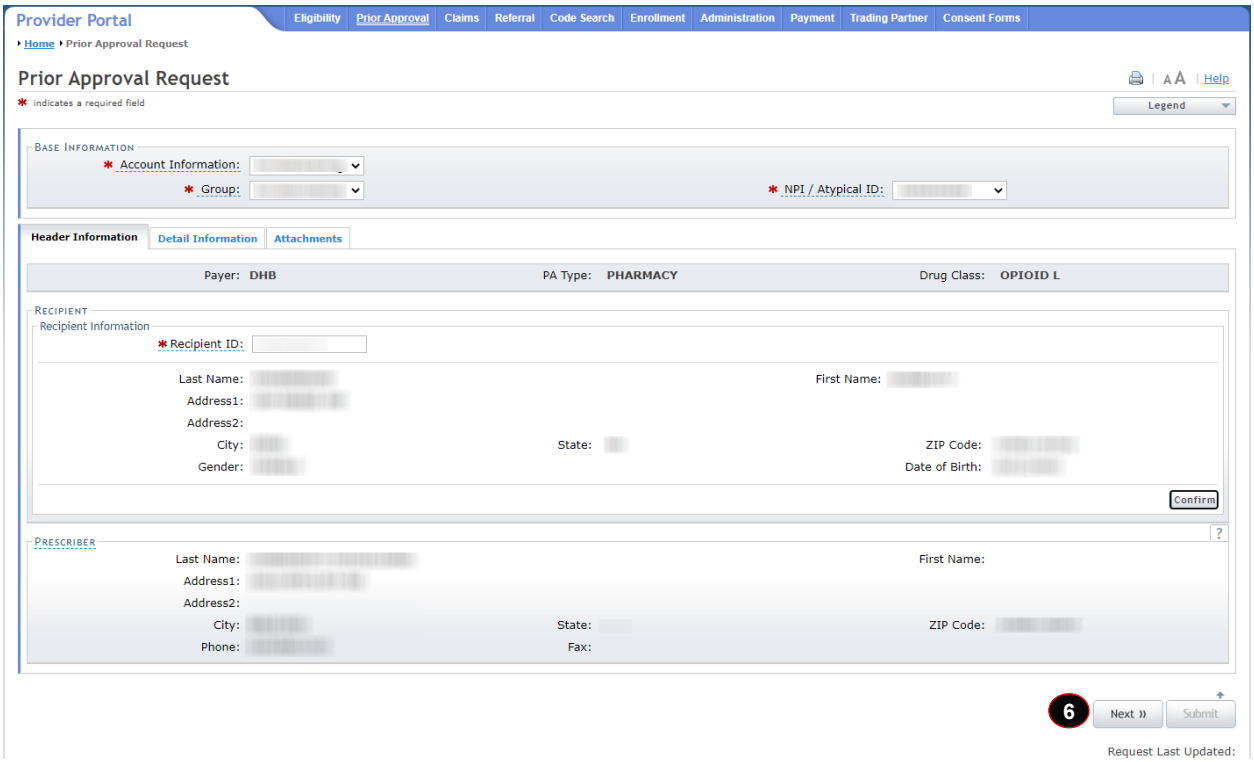
- The beneficiary shall have a diagnosis of chronic pain syndrome of at least 4 weeks duration.
- Prior approval is required for total daily doses greater than the allowed maximums. Refer to Appendix A, Morphine Equivalency Values to view the list of maximum daily dosages for long-acting opioid analgesics.
- 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.



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.

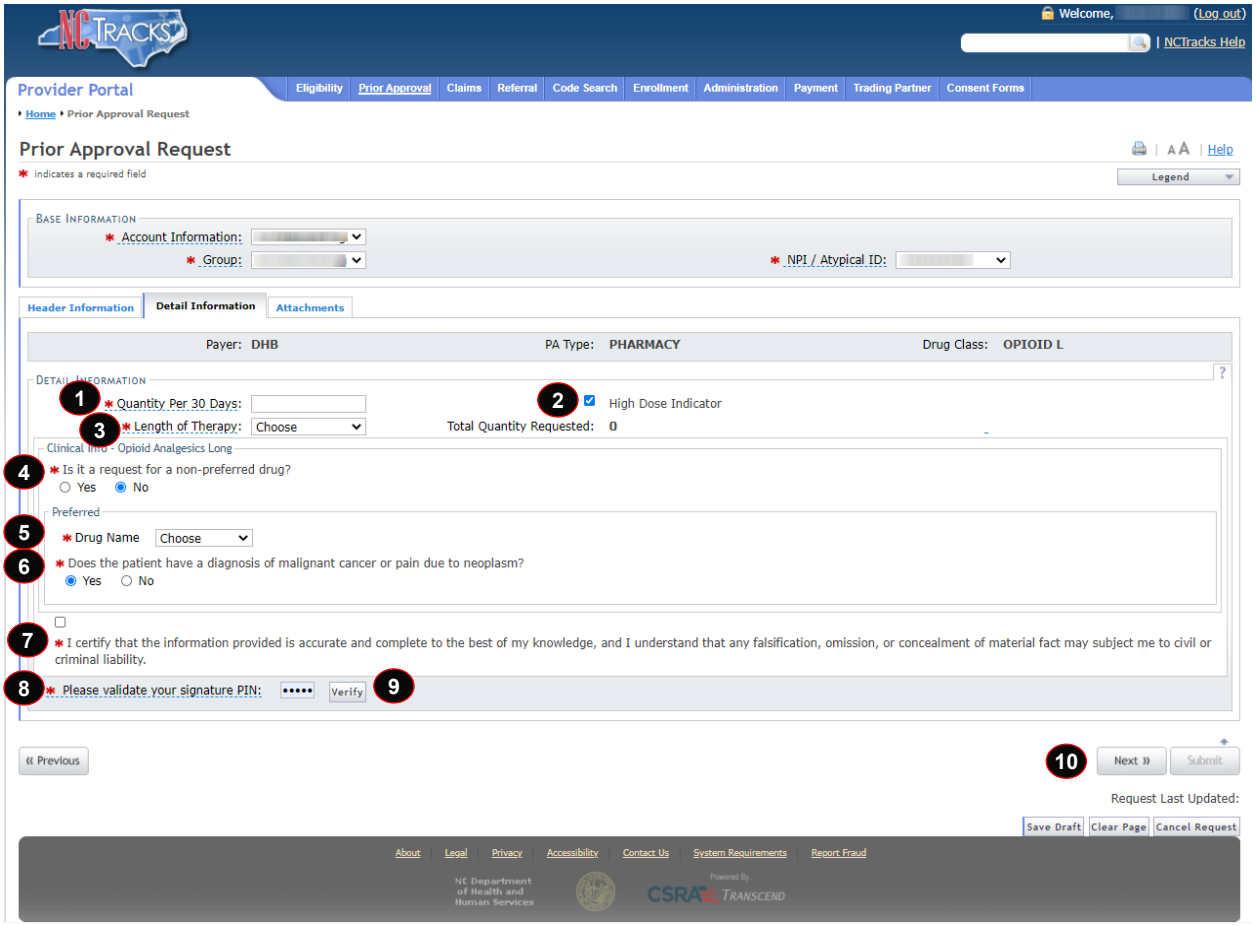
The recipient's demographics display.



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

Diagnosis of Malignant Cancer or Pain Due to Neoplasm

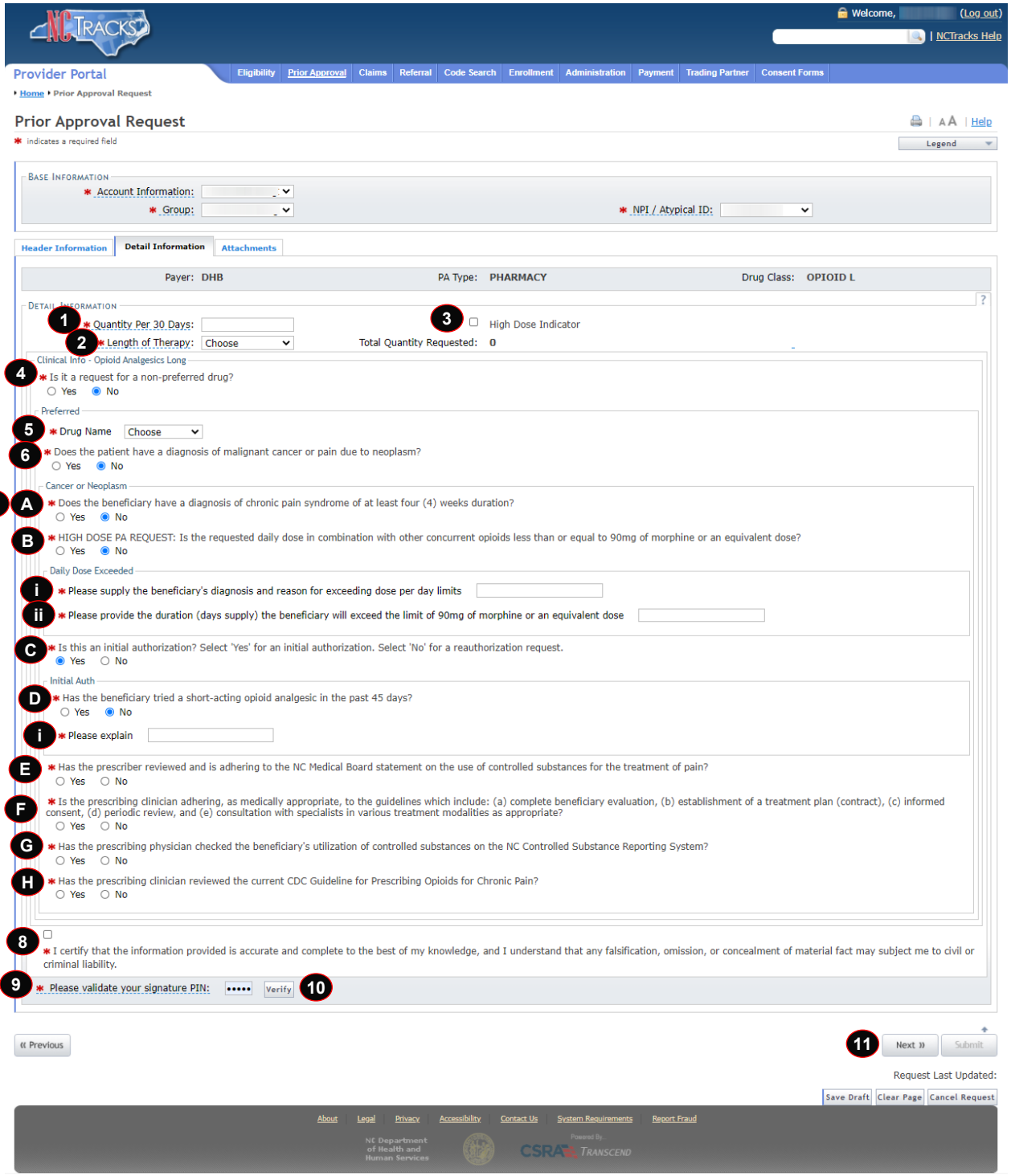
The Detail tab of the page allows an external user (i.e., provider) to enter prior approval detail information.



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



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	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? 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**. 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**. 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)

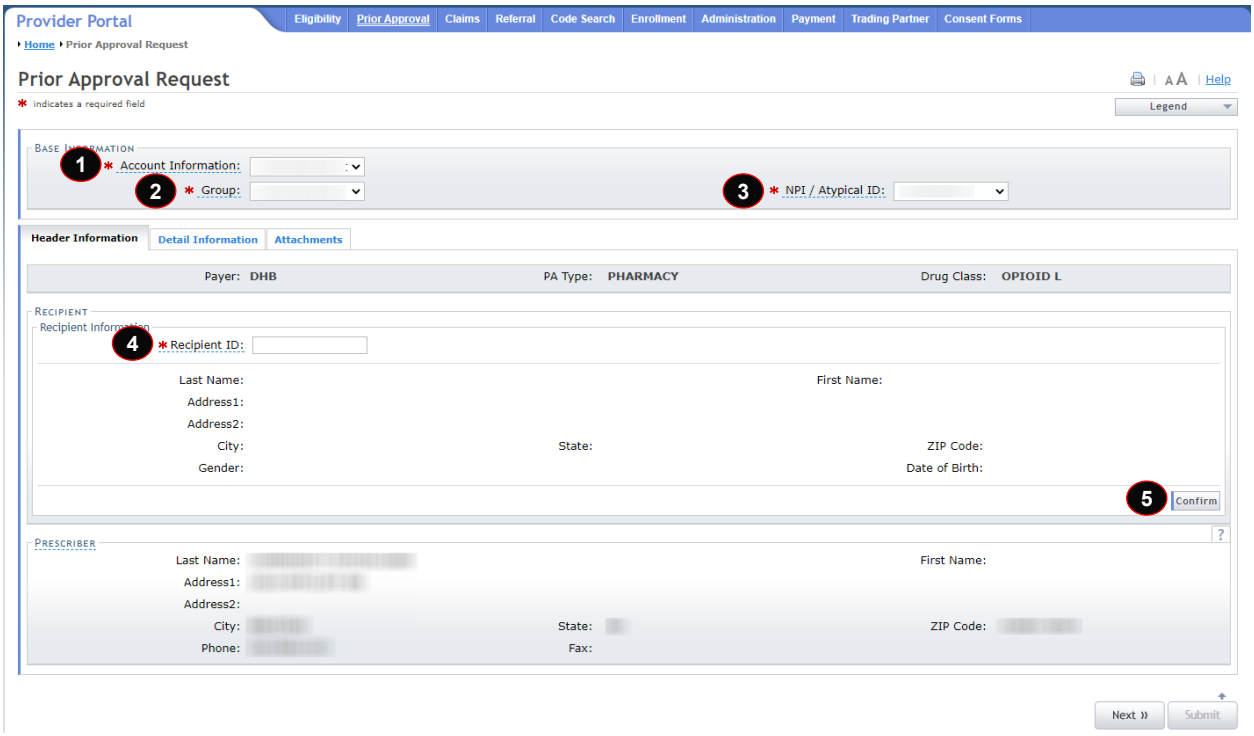
Step	Action
	periodic review, and (e) consultation with specialists in various treatment modalities as appropriate? G. Has the prescribing physician checked the beneficiary's utilization of controlled substances on the NC Controlled Substance Reporting System? H. Has the prescribing clinician reviewed 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

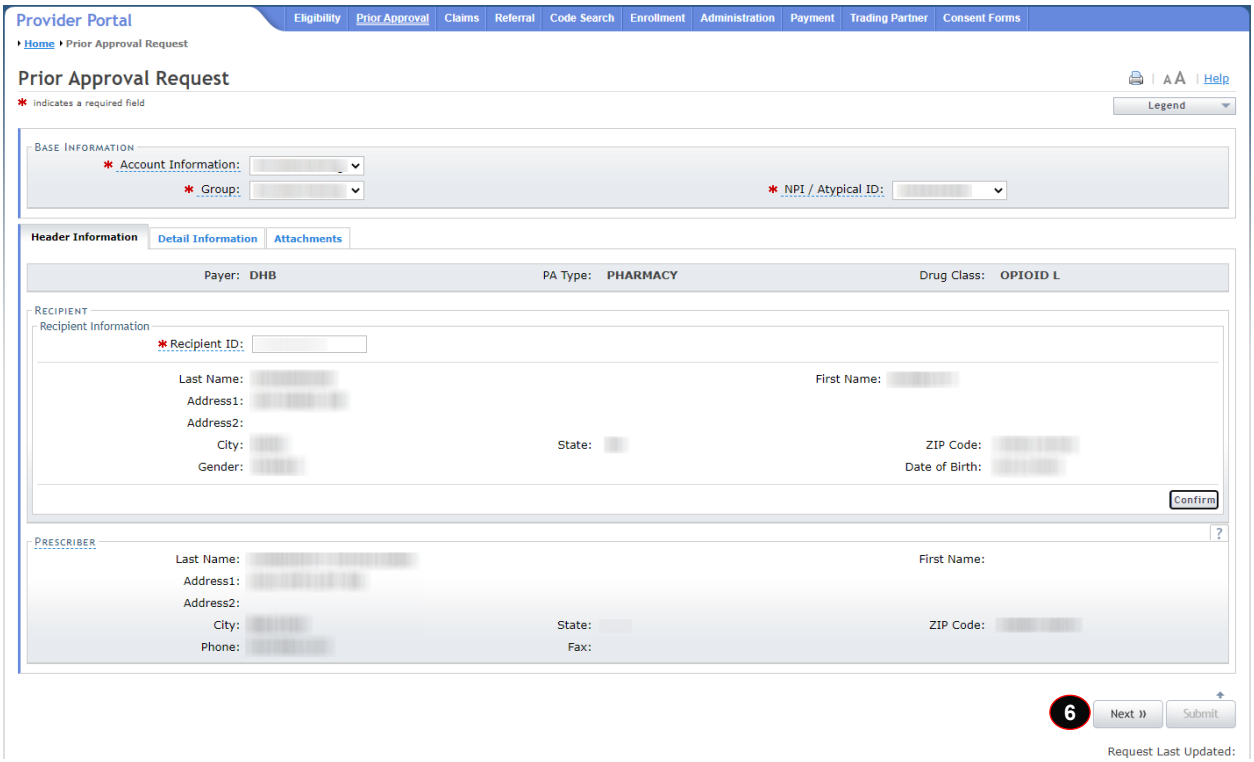
- The beneficiary shall have a diagnosis of chronic pain syndrome of at least 4 weeks duration.
- Prior approval is required for all non-preferred long-acting opioids.
- Prior approval requests should include the beneficiary's diagnosis and reason for exceeding limits.
- Prior approval requests may be 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.



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.

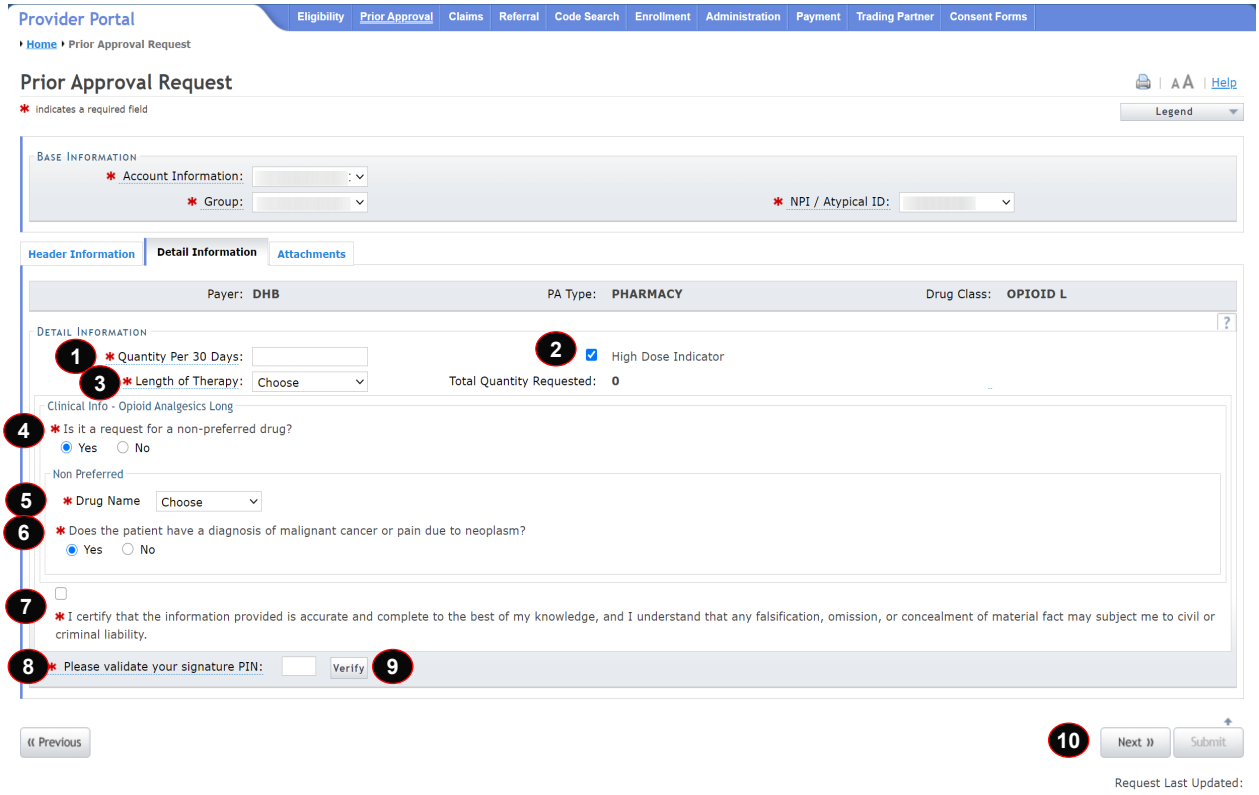
The recipient's demographics display.



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

Diagnosis of Malignant Cancer or Pain Due to Neoplasm

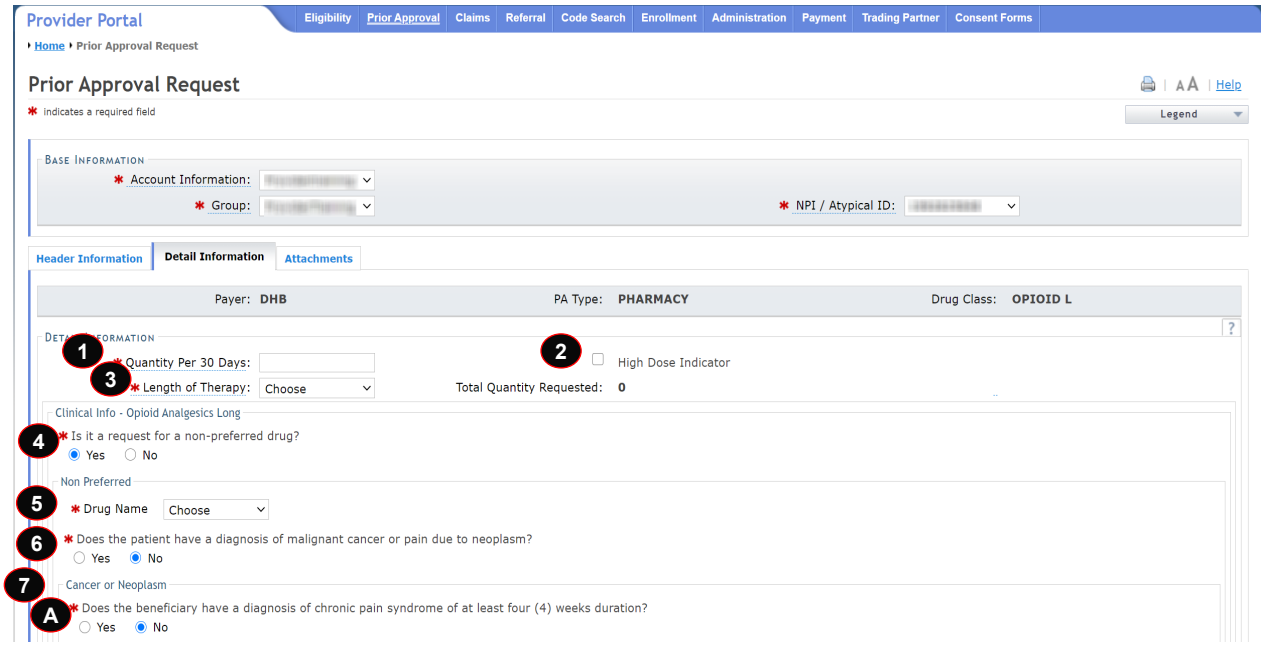
The Detail tab of the page allows an external user (i.e., provider) to enter prior approval detail information.



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.

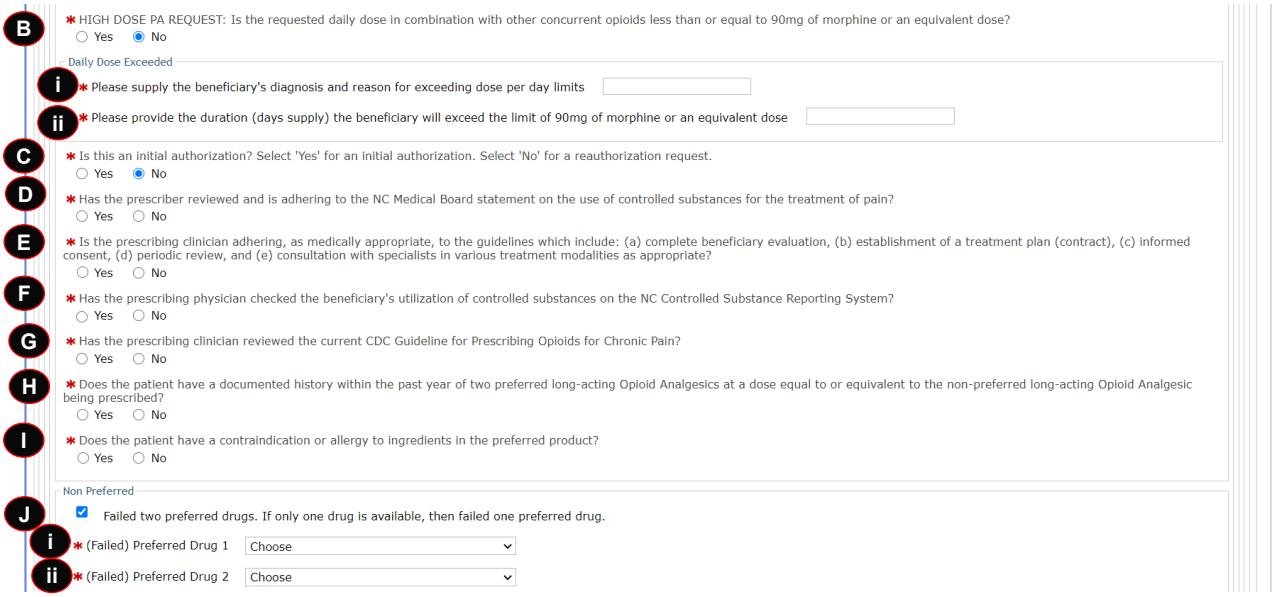
No Diagnosis of Malignant Cancer or Pain Due to Neoplasm

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



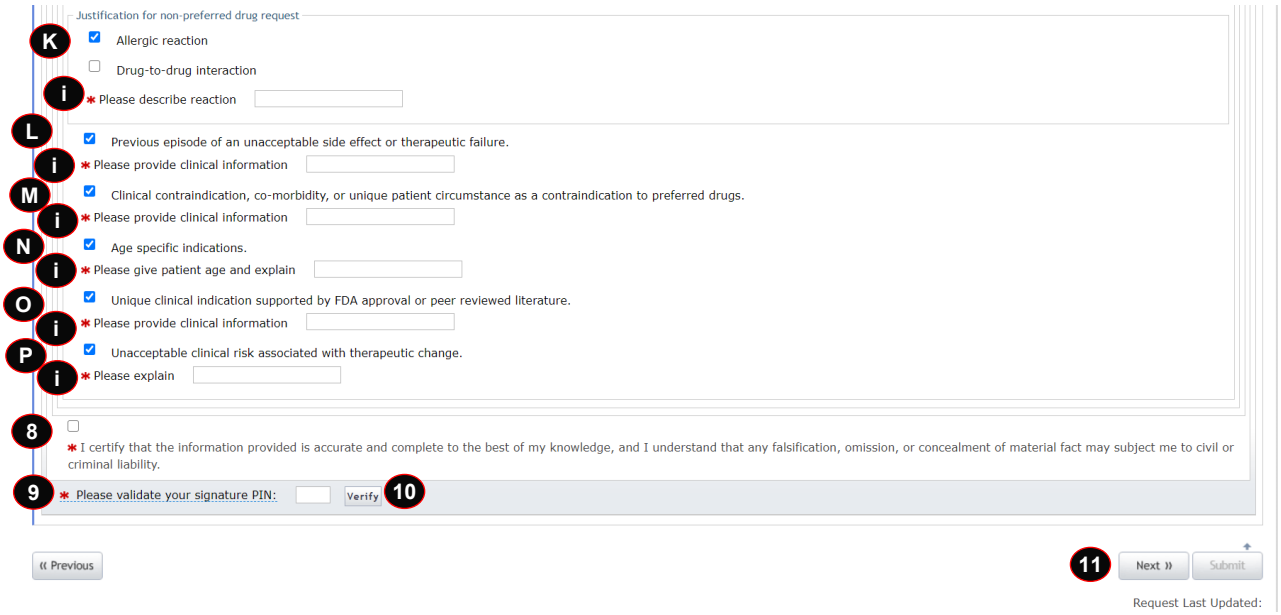
Step	Action
1	Enter the **Quantity Per 30 Days**.
2	The **High Dose Indicator** cannot be edited on the Provider portal. The default value is **No** (unchecked). The value will be systematically updated to **Yes** (checked) when the response to '**Does the patient have a diagnosis of malignant cancer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

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



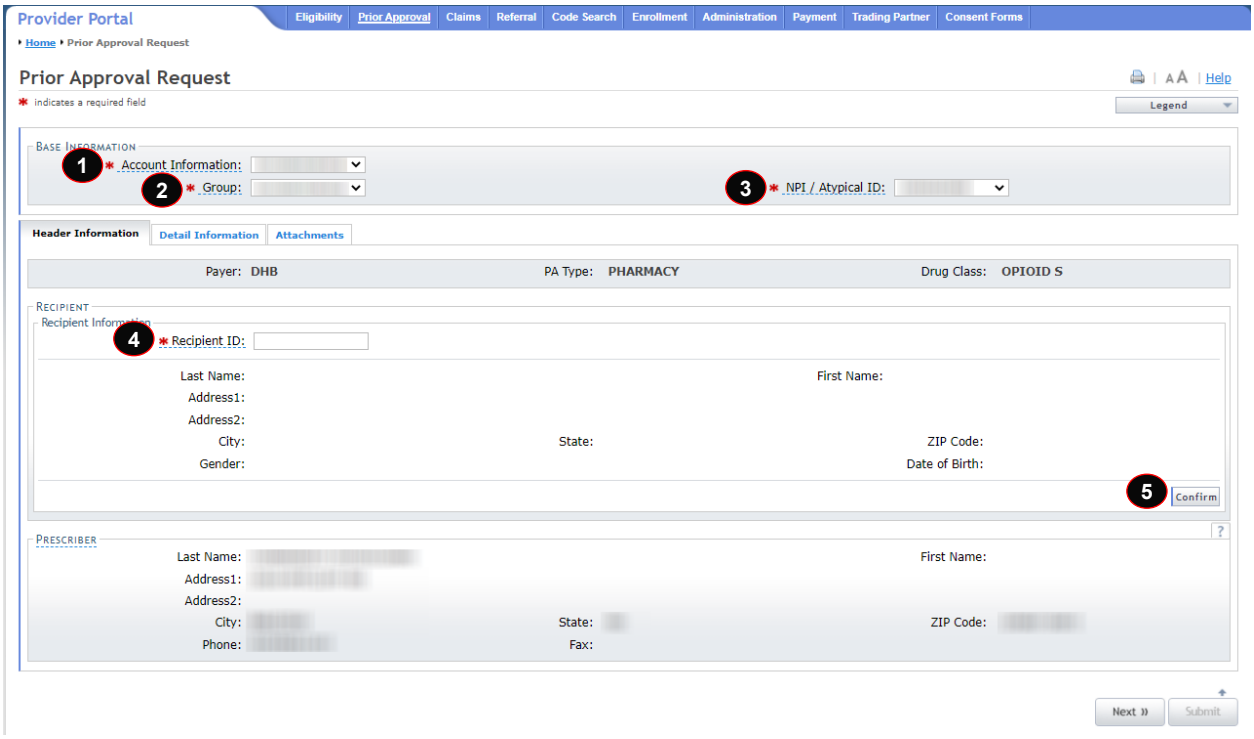
Step	Action
	I. Allergic reaction J. Drug-to-drug interaction i. Please describe reaction: K. Previous episode of an unacceptable side effect or therapeutic failure. i. Please provide clinical information: L. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication 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 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.

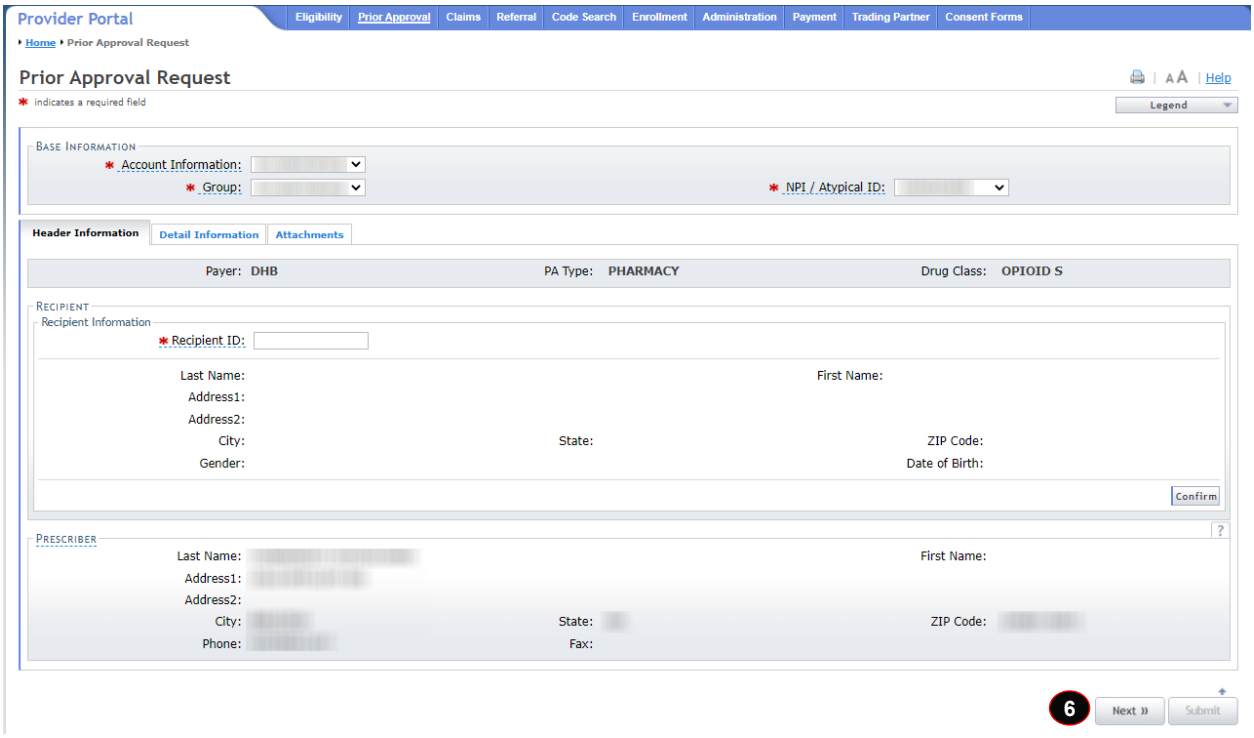
The Header tab of the page allows an external user (i.e., provider) to enter Prior Approval common header information.



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.

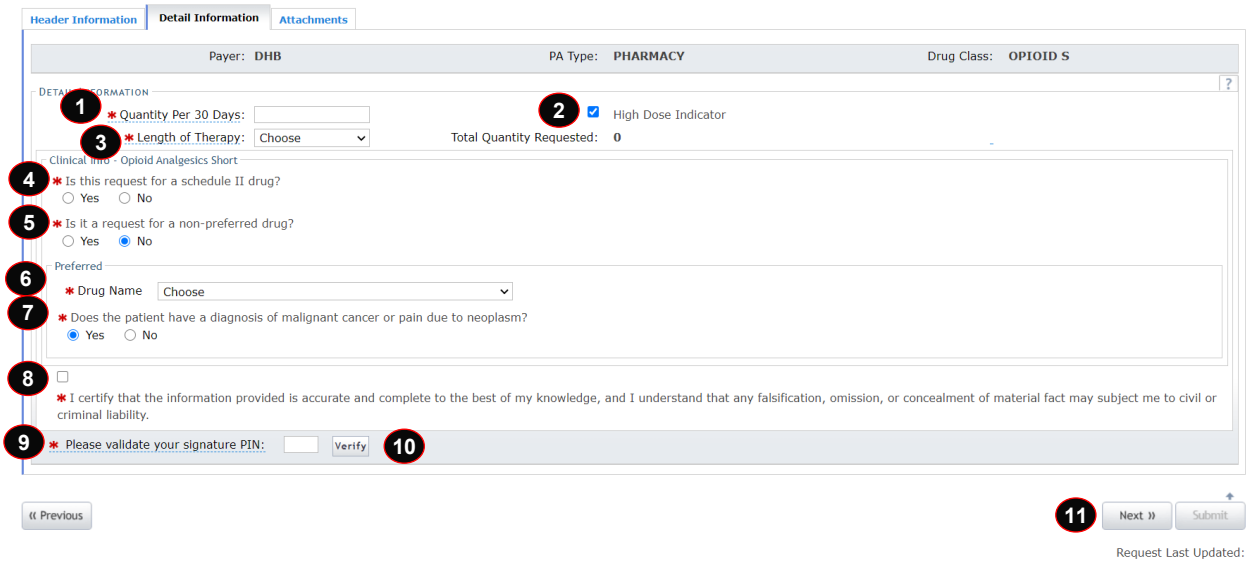
The recipient's demographics display.



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

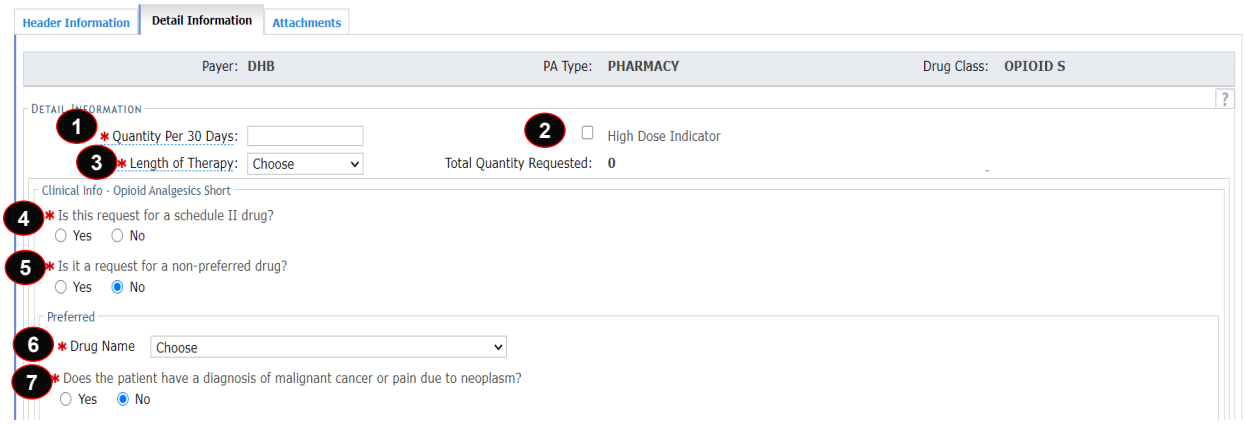
Diagnosis of Malignant Cancer or Pain Due to Neoplasm

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

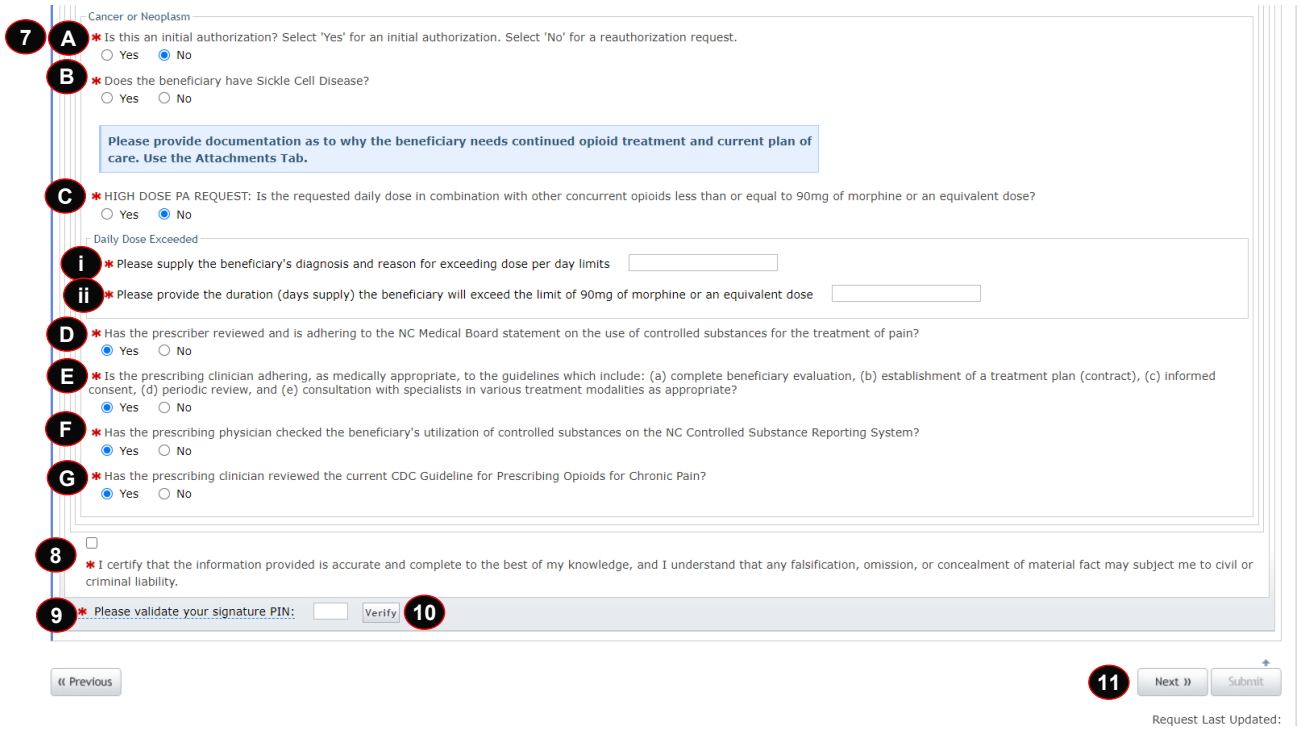


Step	Action
1	Enter an amount in the **Quantity Per 30 Days** field.
2	The **High Dose Indicator** cannot be edited on the Provider portal. The default value is **No** (unchecked). The value will be systematically updated to **Yes** (checked) when the response to '**Does the patient have a diagnosis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



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.



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. **Note**: Supporting documentation is required when the response to '**Is this an initial authorization?**' is **No**. B. 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**. 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? E. Is the prescribing clinician adhering, as medically appropriate, to the guidelines which include: (a) complete beneficiary evaluation, (b)

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.

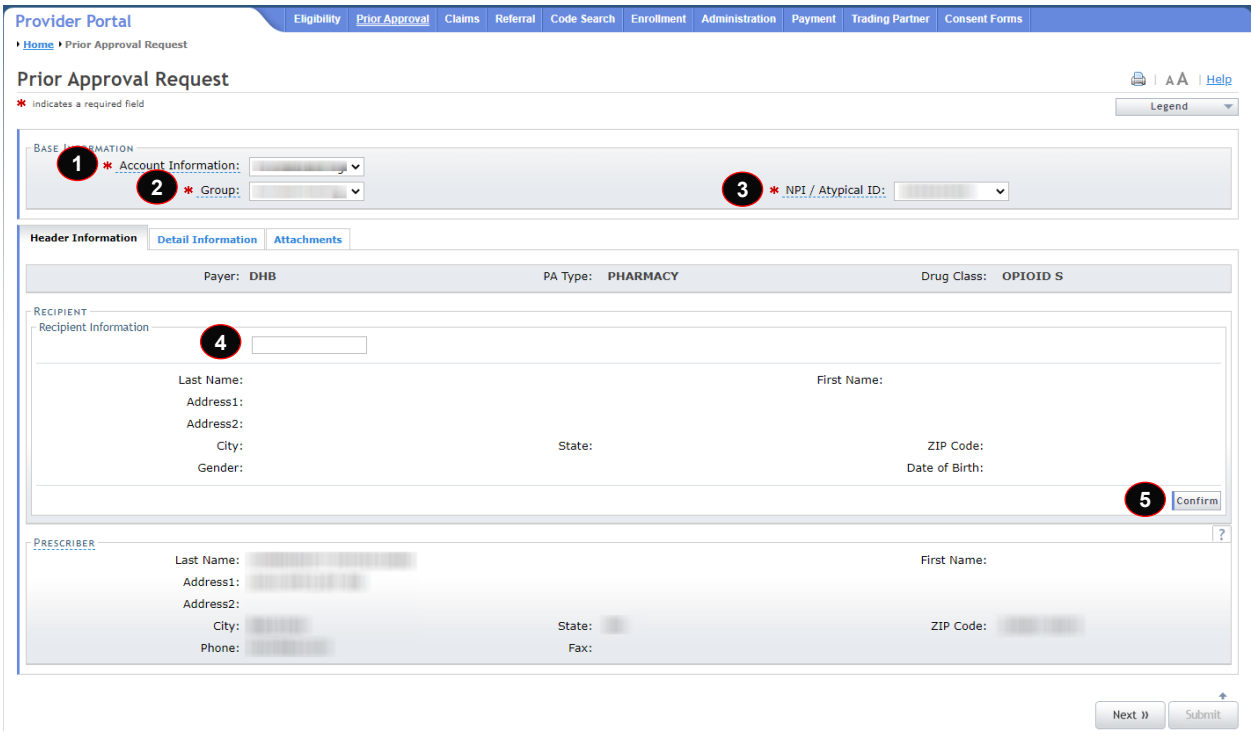
Prior Approval Request – Short-Acting Opioid Analgesics – Non-Preferred

SHORT-ACTING NON-PREFERRED OPIOID ANALGESICS

- Prior approval is required for total daily doses greater than the allowed maximums. Refer to 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.

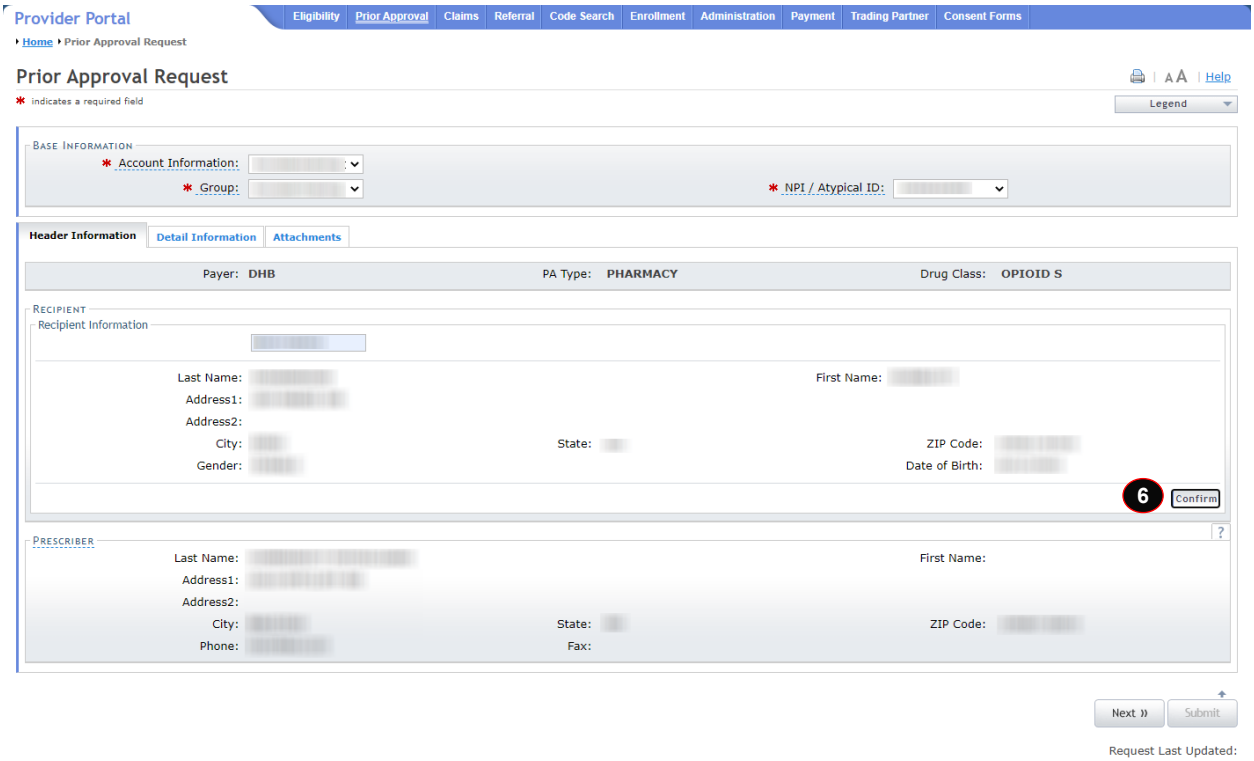
The beneficiary must have a documented failure within the past year of two preferred opioid analgesics at a dose equivalent to the dose of the product being prescribed or a known documented contraindication to one or more of the preferred ingredients.

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



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.

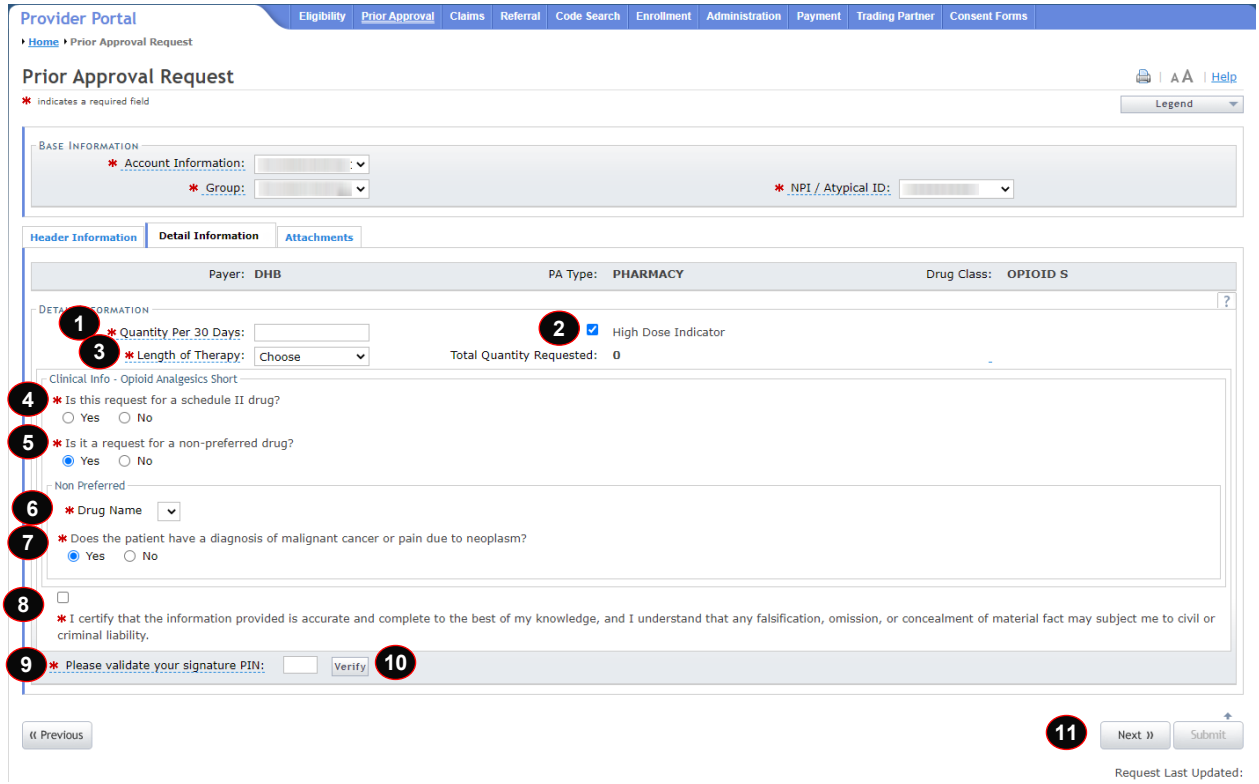
The recipient's demographics display.



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

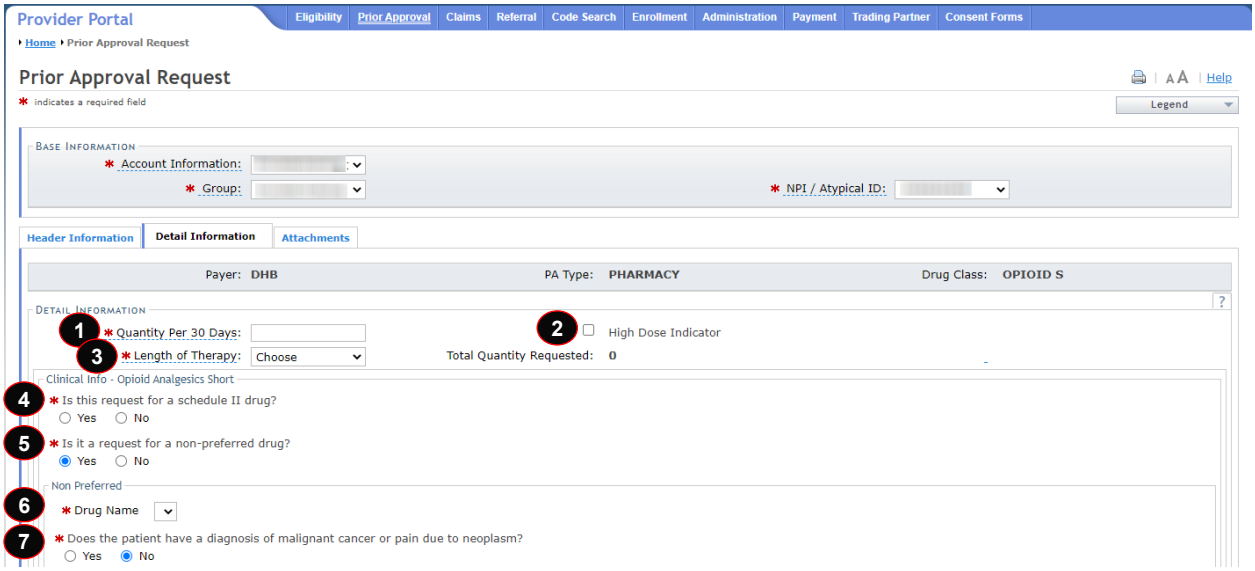
Diagnosis of Malignant Cancer or Pain Due to Neoplasm

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

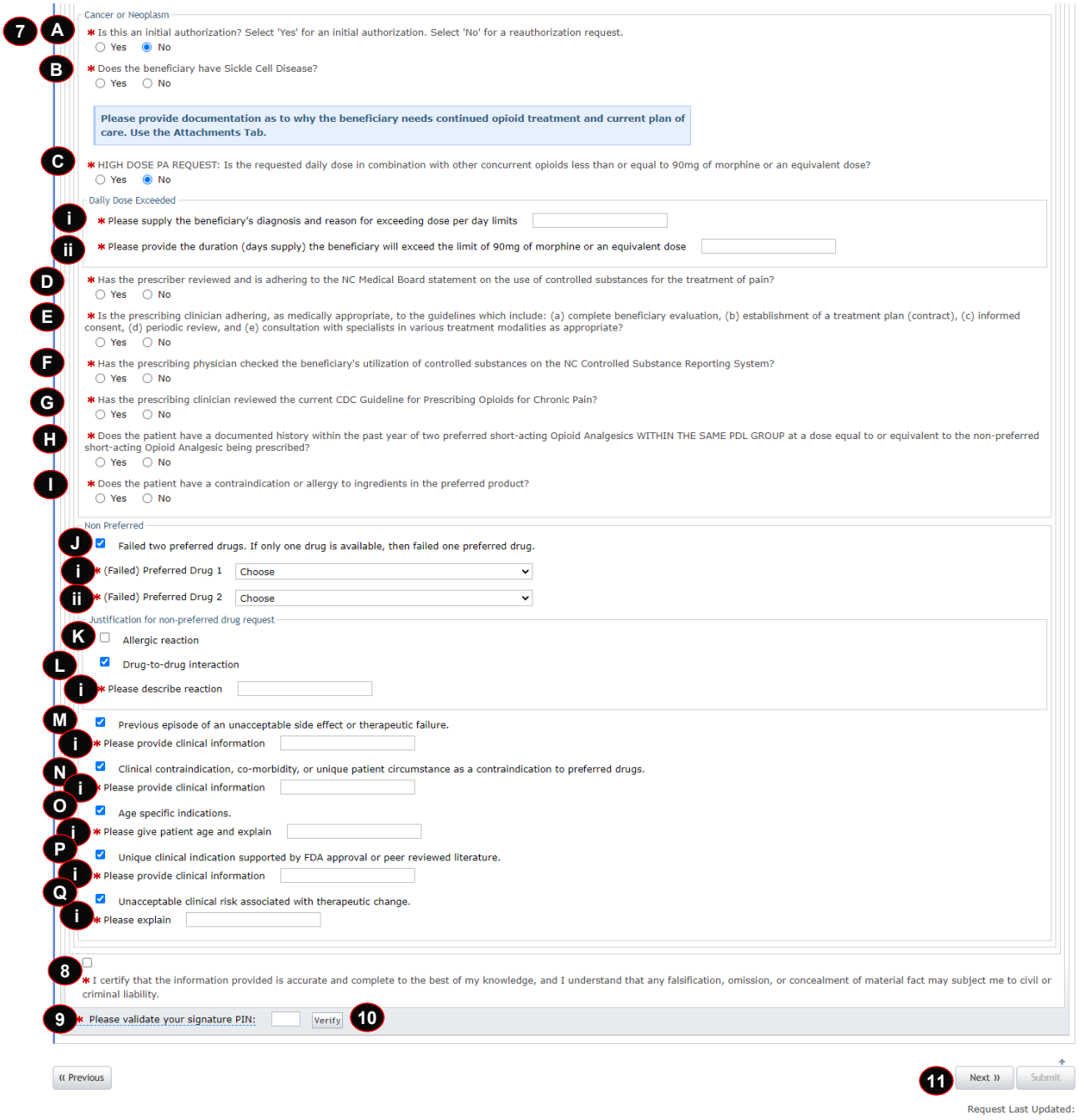


Step	Action
1	Enter an amount in the **Quantity Per 30 Days** field.
2	The **High Dose Indicator** cannot be edited on the Provider portal. The default value is **No** (unchecked). The value will be systematically updated to **Yes** (checked) when the response to '**Does the patient have a diagnosis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



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).



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
	Note: Supporting documentation is required when the response to '**Is this an initial authorization?**' is **No**. B. 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**. 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? 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