Pennsylvania
Department of Human Services

Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANALGESICS, ACUTE PAIN AGENTS PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

Prior authorization guidelines for **Analgesics, Acute Pain Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.

☐New request ☐Renewal request	Total pages: ___________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	
Dose/directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Dx code (*required*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

For ALL requests: Does the beneficiary have a history of trial and failure of or a contraindication or an intolerance to both of the following? ☐Acetaminophen ☐An NSAID	☐Yes ☐No	*Submit documentation.*
For JOURNAVX (suzetrigine): Has the beneficiary received a 14-day supply of Journavx (suzetrigine) in the past 90 days?	☐Yes ☐No	*Submit documentation.*
For JOURNAVX (suzetrigine): If the beneficiary has used Journavx (suzetrigine) in the past, is the beneficiary experiencing a new episode of moderate to severe acute pain that is separate and distinct from the previous episode that was treated with Journavx (suzetrigine)?	☐Yes ☐No ☐N/A	*Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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