OPIOID DEPENDENCE TREATMENTS (ORAL) PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

Keystone First | PERFORMRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	total # pages:	Name of office contact:
Contact's phone number:		Facility contact/phone:

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	
State license #:	NPI:	DATA 2000 waiver DEA number:
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

CLINICAL INFORMATION

Preferred drug requested

☐ buprenorphine SL tablet (***clinical prior authorization required)
☐ buprenorphine/naloxone SL film
☐ buprenorphine/naloxone SL tablet

Non-preferred drug requested

☐ Bunavail buccal film
☐ Lucemyra – go to question 9
☐ Suboxone SL film
☐ Zubsolv SL tablet
☐ _____

Strength:	Directions:	Quantity:	Requested duration:
Diagnosis (submit documentation):		Dx code (required):	

1. Is the patient being treated for a diagnosis of opioid use disorder?	☐ Yes – Submit documentation of diagnosis. ☐ No – Submit medical literature supporting the use of the requested agent for the diagnosis.	
2. Did the prescriber or prescriber's delegate search the PDMP to review the patient's controlled substance prescription history before issuing this prescription for the requested medication?	☐ Yes ☐ No	*Submit documentation.*
3. For non-preferred requests, does the patient have a history of trial and failure, contraindication, or intolerance of the preferred agent?	☐ Yes – list medications tried:_____ ☐ No	
4. ***For requests for an oral buprenorphine agent that does not contain naloxone, do any of the following apply to the patient? Check all that apply. ☐ patient is pregnant ☐ patient is breastfeeding ☐ the requested agent is being used for induction therapy	☐ Yes ☐ No	*Submit documentation.*
5. Does the request exceed the daily dose limit of 16 mg of buprenorphine per day?	☐ Yes – Submit documentation supporting requested dose and **continue to question 6**. ☐ No – Skip to question 7.	

6. <u>For requests above the daily dose limit of 16 mg of buprenorphine per day</u>, check all of the following that apply to the patient, <u>submit documentation for each</u>, and **continue to question 7**.
   - ☐ Has an initial or scheduled evaluation by a licensed D&A provider or Single County Authority (SCA) for the determination of level of care
   - ☐ Is participating in a program with a licensed D&A or behavioral health provider at the recommended level of care
   - ☐ Is participating in a substance abuse or behavioral health counseling or treatment program or an addictions recovery program
   - ☐ Has results of a recent UDS (including licit and illicit drugs with abuse potential) demonstrating compliance with oral buprenorphine therapy

7. Is the patient taking a benzodiazepine or other CNS depressant?	☐ Yes – Submit patient's medication list and **continue to question 8**. ☐ No – Submit patient's medication list.	

8. <u>For a patient who is taking a benzodiazepine (BZD) or other CNS depressant in addition to the requested buprenorphine agent,</u> check all of the following that apply to the patient and <u>submit documentation for each.</u>
   - ☐ Was educated about the serious risks of concomitant use of buprenorphine with the BZD or other CNS depressant
   - ☐ Has a plan in place to taper the BZD or other CNS depressant
   - ☐ Is receiving the BZD or other CNS depressant for anxiety or insomnia, and this diagnosis was verified
   - ☐ Is receiving the BZD or other CNS depressant for anxiety or insomnia, and other treatment options for the diagnosis were considered
   - ☐ Concomitant use of buprenorphine with the BZD or other CNS depressant is medically necessary
   - ☐ Has results of urine or blood screening

9. <u>For Lucemyra requests</u>, does the patient have a history of trial and failure, contraindication, or intolerance of **clonidine tablet**?	☐ Yes ☐ No	*Submit documentation.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: