OPIOID DEPENDENCE TREATMENTS (ORAL) PRIOR AUTHORIZATION FORM

(form effective 1/5/21)

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 agents?
   ☐ 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
   ☐ contraindication or intolerance to naloxone
   ☐ Yes
   ☐ No
   Submit documentation.
5. Does the request exceed the daily dose limit of 24 mg of buprenorphine per day?
   ☐ Yes – Submit documentation supporting requested dose and **continue to question 6**.
   ☐ No
6. **For ALL requests above the daily dose limit of 24 mg of buprenorphine per day**, check all of the following that apply to the patient, submit documentation for each, and **continue to question 7**.
   ☐ Has documentation of an evaluation to determine the recommended level of care
   ☐ Is participating in a substance abuse or behavioral health counseling or treatment program or an addictions recovery program
   ☐ Has a recent urine drug screen for drugs with the potential for abuse
7. **For renewal requests above the daily dose limit of 24 mg of buprenorphine per day, does the patient have a recent urine drug screen that is positive for buprenorphine and norbuprenorphine?**
   ☐ Yes
   ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:

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