pennsylvania
DEPARTMENT OF HUMAN SERVICES

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

OPIOID DEPENDENCE TREATMENTS (ORAL) PRIOR AUTHORIZATION FORM

Prior authorization guidelines and Quantity Limits/Daily Dose Limits are accessible at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		DATA 2000 waiver DEA number:	
Facility contact/phone:		NPI:	State license #:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Preferred drug requested:	☐buprenorphine SL tablet ***(***clinical prior authorization required)*** ☐Suboxone SL film	**Non-preferred drug requested:**	☐Bunavail buccal film ☐buprenorphine/naloxone SL tablet ☐*Lucemyra – go to question* ***(9)*** ☐Zubsolv SL tablet ☐_____
Strength:	Directions:	Qty:	Requested duration:
Diagnosis *(submit documentation)*:			Dx code (*required*):

1. Is the beneficiary 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 beneficiary's controlled substance prescription history before issuing this prescription for the requested medication?	☐Yes ☐No	*Submit documentation.*
3. ***For non-preferred requests***, does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agent – **Suboxone film**?	☐Yes ☐No	*Submit documentation for all agents tried.*
4. *******For requests for an oral buprenorphine agent that does not contain naloxone***, do any of the following apply to the beneficiary? Check all that apply. ☐beneficiary is pregnant ☐the requested agent is being used for induction therapy ☐beneficiary is breastfeeding	☐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. ***For requests above the daily dose limit of 16 mg of buprenorphine per day,*** check all of the following that apply to the beneficiary, submit documentation for each, *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 beneficiary taking a benzodiazepine or other CNS depressant?	☐Yes – *Submit beneficiary's medication list and* ***continue to question 8.*** ☐No – *Submit beneficiary's medication list and send request and documentation to DHS.*	
8. ***For a beneficiary who is taking a benzodiazepine (BZD) or other CNS depressant in addition to the requested buprenorphine agent***, check all of the following that apply to the beneficiary and submit documentation for each. ☐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. ***For Lucemyra requests,*** does the beneficiary 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 TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: