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

PROBUPHINE (buprenorphine implant) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Opioid Dependence Treatments and Quantity Limits/Daily Dose Limits are accessible on the Department's Pharmacy Services website 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

Medication requested: Probuphine 74.2 mg implant	Quantity: ☐1 implant kit (contains 4 implants) ☐other:
Requested duration: ☐6 months ☐other:	Dx code (*required*):
Diagnosis (*submit documentation*):	
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 beneficiary's 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 Probuphine?	☐Yes ☐No *Submit documentation.*
INITIAL requests	
1. Has the beneficiary achieved and sustained prolonged clinical stability on transmucosal buprenorphine?	☐Yes ☐No *Submit documentation.*
2. Is the beneficiary stable and on no more than 8 mg per day of oral buprenorphine for at least the last three (3) months without any need for supplemental dosing or adjustments?	☐Yes ☐No *Submit documentation.*

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

Prescriber Signature:	**Date:**

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