

**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 <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> 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**

<b>Medication requested:</b> Probuphine 74.2 mg implant	Quantity: <input type="checkbox"/> 1 implant kit (contains 4 implants) <input type="checkbox"/> other:
Requested duration: <input type="checkbox"/> 6 months <input type="checkbox"/> other:	Dx code ( <i>required</i> ):
Diagnosis ( <i>submit documentation</i> ):	
1. Is the beneficiary being treated for a diagnosis of opioid use disorder?	<input type="checkbox"/> Yes – <i>Submit documentation of diagnosis.</i> <input type="checkbox"/> No – <i>Submit medical literature supporting the use of the requested agent for the beneficiary's diagnosis.</i>
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?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
INITIAL requests	
1. Has the beneficiary achieved and sustained prolonged clinical stability on transmucosal buprenorphine?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
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?	<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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