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 PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Opioid Dependence Treatments** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
Facility contact name/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:
Directions:	Quantity:	Requested duration:
Diagnosis *(submit documentation)*:		Dx code (*required*):
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.*

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

1. **For a NON-PREFERRED ORAL buprenorphine product (eg, film, tablet):**
   - ☐Tried and failed or has a contraindication or an intolerance to the preferred ORAL buprenorphine Opioid Dependence Treatments (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

2. **For a non-preferred NON-ORAL buprenorphine product (eg, injection):**
   - ☐Tried and failed or has a contraindication or an intolerance to the preferred NON-ORAL buprenorphine Opioid Dependence Treatments (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

3. **For Lucemyra (lofexidine):**
   - ☐Tried and failed or has a contraindication or an intolerance to clonidine tablet

4. **For an ORAL buprenorphine product that DOES NOT CONTAIN NALOXONE (eg, Subutex/buprenorphine SL tablet):**
   - ☐Beneficiary is pregnant
   - ☐Beneficiary is breastfeeding
   - ☐The requested drug is being used for induction therapy
   - ☐Has a contraindication or history of intolerance to naloxone

5. **For an ORAL buprenorphine product ABOUT THE DAILY DOSE LIMIT OF 24 MG of buprenorphine per day:**
   - ☐Is prescribed a daily dose consistent with medically accepted prescribing practices and standards of care
   - ☐Has an initial or scheduled 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 results of a recent UDS for licit and illicit drugs with abuse potential
   - ☐If already established on buprenorphine, has results of a recent UDS demonstrating compliance with oral buprenorphine therapy

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

Prescriber Signature:	**Date**: