

## OPIOID DEPENDENCE TREATMENTS (ORAL) 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>.

<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:	
Name of facility contact:		NPI:	State license #:	
Facility's phone number:			Street address:	
Beneficiary name:		Suite #:	City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

### **CLINICAL INFORMATION**

Drug requested:	Strength:	Dosage form:
Directions:	Qty:	Requested duration:
Diagnosis ( <i>submit documentation</i> ):		Dx code ( <i>required</i> ):
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?		<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
For <b>NON-PREFERRED oral buprenorphine agents</b> , does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred oral buprenorphine agents? Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred agents.		<input type="checkbox"/> Yes <i>Submit documentation for all agents tried.</i> <input type="checkbox"/> No
For requests for an <b>ORAL BUPRENORPHINE AGENT THAT DOES NOT CONTAIN NALOXONE</b> (i.e., <b>buprenorphine SL tablet</b> ), do any of the following apply to the beneficiary? Check all that apply. <input type="checkbox"/> Beneficiary is pregnant <input type="checkbox"/> Beneficiary is breastfeeding <input type="checkbox"/> The requested agent is being used for induction therapy		<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No
For requests <b>ABOVE THE DAILY DOSE LIMIT OF 24 MG of buprenorphine per day</b> , check all of the following that apply to the beneficiary and submit documentation for each. <input type="checkbox"/> Has an initial or scheduled evaluation by a licensed D&A provider or Single County Authority (SCA) for the determination of level of care <input type="checkbox"/> Is participating in a program with a licensed D&A or behavioral health provider at the recommended level of care <input type="checkbox"/> Is participating in a substance abuse or behavioral health counseling or treatment program or an addictions recovery program <input type="checkbox"/> Has results of a recent UDS (including licit and illicit drugs with abuse potential) demonstrating compliance with oral buprenorphine therapy		
For <b>LUCEMYRA requests</b> , does the beneficiary have a history of trial and failure, contraindication, or intolerance of <b>clonidine tablet</b> ?		<input type="checkbox"/> Yes <i>Submit documentation.</i> <input type="checkbox"/> No

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

Prescriber Signature:	Date:
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