

OPIOID DEPENDENCE TREATMENTS (ORAL) PRIOR AUTHORIZATION FORM

(form effective 1/1/20)



Fax to PerformRxSM at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total # pages:	Name of office contact:
Contact's phone number:		Facility contact/phone:	
PATIENT INFORMATION			
Patient name:		Patient ID #:	DOB:
Street address:		Apt. #:	City/state/zip:
PRESCRIBER INFORMATION			
Prescriber name:		Specialty:	
State license #:	NPI:	DATA 2000 waiver DEA number:	
Street address:		Suite #:	City/state/zip:
Phone:		Fax:	
CLINICAL INFORMATION			
Preferred drug requested		Non-preferred drug requested	
<input type="checkbox"/> buprenorphine SL tablet (**clinical prior authorization required)		<input type="checkbox"/> Bunavail buccal film <input type="checkbox"/> Lucemyra – go to question 9 <input type="checkbox"/> Suboxone SL film	
<input type="checkbox"/> buprenorphine/naloxone SL film <input type="checkbox"/> buprenorphine/naloxone SL tablet		<input type="checkbox"/> Zubsolv SL tablet <input type="checkbox"/> _____	
Strength:	Directions:	Quantity:	Requested duration:
Diagnosis (submit documentation):			Dx code (required):
1. Is the patient being treated for a diagnosis of opioid use disorder?		<input type="checkbox"/> Yes – Submit documentation of diagnosis. <input type="checkbox"/> 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 patient's controlled substance prescription history before issuing this prescription for the requested medication?			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
3. For non-preferred requests, does the patient have a history of trial and failure, contraindication, or intolerance of the preferred agent?		<input type="checkbox"/> Yes – list medications tried: _____ <input type="checkbox"/> No	
4. ***For requests for an oral buprenorphine agent that does not contain naloxone, do any of the following apply to the patient? Check all that apply. <input type="checkbox"/> patient is pregnant <input type="checkbox"/> patient is breastfeeding <input type="checkbox"/> the requested agent is being used for induction therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
5. Does the request exceed the daily dose limit of 16 mg of buprenorphine per day?		<input type="checkbox"/> Yes – Submit documentation supporting requested dose and continue to question 6. <input type="checkbox"/> 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 patient, submit documentation for each, and continue to question 7.			
<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			
7. Is the patient taking a benzodiazepine or other CNS depressant?		<input type="checkbox"/> Yes – Submit patient's medication list and continue to question 8. <input type="checkbox"/> No – Submit patient's medication list.	
8. For a patient 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 patient and submit documentation for each.			
<input type="checkbox"/> Was educated about the serious risks of concomitant use of buprenorphine with the BZD or other CNS depressant <input type="checkbox"/> Has a plan in place to taper the BZD or other CNS depressant <input type="checkbox"/> Is receiving the BZD or other CNS depressant for anxiety or insomnia, and this diagnosis was verified <input type="checkbox"/> Is receiving the BZD or other CNS depressant for anxiety or insomnia, and other treatment options for the diagnosis were considered <input type="checkbox"/> Concomitant use of buprenorphine with the BZD or other CNS depressant is medically necessary <input type="checkbox"/> Has results of urine or blood screening			
9. For Lucemyra requests, does the patient have a history of trial and failure, contraindication, or intolerance of clonidine tablet?			<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

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