SUBLOCADE (BUPRENORPHINE EXTENDED-RELEASE INJECTION) PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

AmeriHealth Caritas Pennsylvania | PerformRx℠ Next Generation Pharmacy Benefits

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

PRIOR AUTHORIZATION REQUEST INFORMATION		
☐ New request ☐ 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			
Medication requested:	☐ Sublocade 100 mg/0.5 ml injection	Quantity: _____ syringe(s)	Refills: _____
	☐ Sublocade 300 mg/1.5 ml injection	Quantity: _____ syringe(s)	Refills: _____
Directions:			
Diagnosis (submit documentation):			DX code (required):
1. Is the patient 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 patient's 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 Sublocade?			☐ Yes ☐ No — *Submit documentation.*

INITIAL REQUESTS		
1. Did the patient initiate treatment with transmucosal buprenorphine at a dose equivalent to 8 mg to 24 mg of buprenorphine daily?	☐ Yes ☐ No	*Submit documentation.*
2. Has the patient been using a transmucosal buprenorphine product for at least seven (7) days since completing any induction phase?	☐ Yes ☐ No	*Submit documentation.*

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