

OPIATE DEPENDENCE TREATMENTS (Oral) PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for these agents, refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Opiate Dependence Treatments at: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information (PA#: _____)
Pages in this Request: _____ Office Contact Name: _____ Phone: (_____) _____
Recipient name: _____ Recipient ID#: _____ DOB: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DATA 2000 waiver DEA#: _____
NPI#: _____ OR MA Provider ID#: _____ State License#: _____
Prescriber Address: _____ Suite #: _____
City/State/Zip: _____ Phone: (_____) _____ Fax: (_____) _____

MEDICAL INFORMATION

Preferred: buprenorphine tab: 2 mg 8 mg Suboxone film: 2 mg-0.5 mg 4 mg-1 mg 8 mg-2 mg 12 mg-3 mg
(*For prior authorization requests for Vivitrol, please use the Vivitrol fax form)

Non-Preferred: Bunavail film: 2.1 mg/0.3 mg 4.2 mg-0.7 mg 6.4 mg-1 mg
 buprenorphine/naloxone tablet: 2 mg-0.5 mg 8 mg-2 mg
 Zubsolv tablet: 1.4 mg-0.36 mg 5.7 mg-1.4 mg 8.6 mg-2.1 mg 11.4 mg-2.9 mg

Directions: _____ Quantity: _____ Duration of Request: _____ days (Max: 90 days)

Diagnosis: _____ Diagnosis Code: _____ (required)

1. Is the **prescribing provider** enrolled in the Pennsylvania Medical Assistance (MA) Program? Yes No
2. Document the NPI of the provider billing for office visits for opiate use disorder treatment: _____. If the **prescribing provider** is different from the **billing provider**, is the billing provider enrolled in the MA Program? Yes No
3. Is the MA recipient, or another person, being charged for the MA recipient's office visits?
 Yes No Prescriber signature (required): _____
4. Is request above the quantity limit (QL)*? Yes (submit supporting documentation) No

*QL Listing accessible at: <http://www.dhs.state.pa.us/provider/doingbusinesswithdhpw/pharmacyservices/quantitylimitslist/index.htm>

5. **Non-Preferred request:** Has the Recipient tried & failed (or have a contraindication or intolerance to) the preferred agents listed above? Yes (documentation required) No

All INITIAL Requests:

1. Is the Recipient diagnosed with opioid use disorder as documented by a history that meets the current Diagnostic & Statistical Manual (DSM) criteria? Yes (documentation of criteria met is required) No
2. Is the Recipient diagnosed with opioid use disorder, as documented by **one** of the following (check & submit documentation)?
 An initial urine drug screen (UDS) that supports an opioid use disorder diagnosis (including testing for substances of abuse)
 Active withdrawal documented by a Clinical Opiate Withdrawal Scale (COWS) score of ≥ 9 at treatment initiation
 A history of opioid use disorder with cravings
3. Check all that apply to the Recipient & submit supporting documentation:
 Signed a consent form authorizing release of his/her medical information as it relates to this request
 Initially evaluated by a licensed Drug & Alcohol (D&A) provider or Single County Authority (SCA) to determine level of care
 Participating in, or referred to, a licensed D&A program, as recommended in the initial evaluation
 Had a mental health screening performed
 If diagnosed with a co-occurring mental health disorder, is receiving (or has been referred for) treatment
4. Is the Recipient taking a benzodiazepine? Yes – list agent: _____ (documentation required) No

All RENEWAL Requests: Document treatment initiation date: _____

1. Has the Recipient been receiving this treatment for more than 12 months? Yes – complete question (1a) No
1a. Has a clinical assessment of dosage and effectiveness been performed? Yes (documentation required) No
2. Check all that apply to the Recipient and submit supporting documentation:
 Recent UDS – date: _____ (UDS must include buprenorphine, norbuprenorphine, oxycodone, fentanyl, licit & illicit drugs)
 Abstinence from alcohol
 Participation in (or successful completion of) a licensed D&A program
 Upon successful completion of the licensed program, participation in a substance abuse or behavioral health counseling or treatment program, or an addictions recovery program
 If diagnosed with a co-occurring mental health disorder, continues to receive treatment for that condition
3. Is the Recipient taking a benzodiazepine? Yes – list agent: _____ (documentation required) No

PLEASE SEND COMPLETED FORM & SUPPORTING CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ Date: _____

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