

## OPIATE OVERDOSE AGENTS PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Opiate Overdose Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Opiate Overdose Agents** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages in request: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
LTC facility contact/phone:			NPI:	MA Provider ID#:
RECIPIENT INFORMATION			Street address:	
Recipient Name:			Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:	

### CLINICAL INFORMATION

<b>Non-preferred medication requested:</b> <span style="margin-left: 200px;"><input type="checkbox"/> Evzio Auto-Injector</span>			
Strength:	Dose/directions:	Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):		DX code ( <i>required</i> ):	
1. Does the Recipient have a history of contraindication or intolerance of the preferred Opiate Dependence Agents? <i>Check all that apply.</i> <input type="checkbox"/> naloxone injection <input type="checkbox"/> Narcan nasal spray		<input type="checkbox"/> Yes – <u>submit all supporting documentation of contraindications or intolerances of the preferred agents</u>  <input type="checkbox"/> No	

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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