Prior Authorization Request Form for Opioid Use Disorder Treatments

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

☐New request ☐Renewal request	total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
Facility contact name/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:
Directions:	Quantity:	Requested duration:
Diagnosis *(submit documentation)*:		Dx code *(required)*:

- **Pennsylvania law requires prescribers to query the PA PDMP each time a patient is prescribed an opioid drug product or benzodiazepine.**
- **Naloxone is available at Pennsylvania pharmacies via standing order from the Secretary of the Department of Health. Pennsylvania Medical Assistance beneficiaries may obtain naloxone free-of-charge through their prescription drug benefit.**

Complete all sections that apply to the member and this request.
Check all that apply and submit documentation for each item.

1. **For a NON-PREFERRED SUBLINGUAL buprenorphine product (eg, film, tablet):**
   ☐Tried and failed or has a contraindication or an intolerance to the preferred SUBLINGUAL buprenorphine Opioid Use Disorder Treatments (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)* (medication, start and end date):_____
2. **For a non-preferred NON-SUBLINGUAL buprenorphine product (eg, injection):**
   ☐Tried and failed or has a contraindication or an intolerance to the preferred NON-SUBLINGUAL buprenorphine Opioid Use Disorder Treatments (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)* (medication, start and end date):_____
3. **For Lucemyra (lofexidine):**
   ☐Tried and failed or has a contraindication or an intolerance to clonidine tablet:_____
4. **For a SUBLINGUAL buprenorphine product ABOVE THE DAILY DOSE LIMIT OF 24 MG of buprenorphine per day:**
   ☐Is prescribed a daily dose consistent with medically accepted prescribing practices and standards of care
   ☐Had an unsatisfactory clinical response (eg, uncontrolled withdrawal or cravings) at the current quantity limit of 24 mg per day
   ☐If already established on buprenorphine, has results of a recent UDS demonstrating compliance with sublingual buprenorphine therapy

ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO (844) 205-3386

Prescriber Signature:	**Date**: