Prior Authorization Request Form for Opioid Dependence Treatment

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/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Does the member have a history of contraindication to the prescribed medication?	☐ Yes ☐ No	*Submit documentation.*
Did the prescriber or prescriber's delegate search the PDMP to review the member's controlled substance prescription history before issuing this prescription for the requested agent?	☐ Yes ☐ No	*Submit documentation.*

☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

LUCEMYRA:

☐ Prescribed a dose and duration of therapy consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

BUPRENORPHINE WITHOUT NALOXONE:

☐ Member meets one of the following:
- ☐ Prescribed for induction therapy
- ☐ Pregnant
- ☐ Breastfeeding
- ☐ History of contraindication or intolerance to naloxone

NON-PREFERRED OPIOID DEPENDENCE TREATMENT:

☐ Oral Buprenorphine, has a therapeutic failure, contraindication or intolerance to the preferred oral buprenorphine Opioid Dependence Treatment:_____

☐ Alpha-2 Adrenergic Agonist, has a therapeutic failure, contraindication or intolerance to the preferred alpha-2 adrenergic agonist Opioid Dependence Treatment:_____

☐ Non-Oral Buprenorphine, has a therapeutic failure, contraindication or intolerance to the preferred non-oral buprenorphine Opioid Dependence Treatment:_____

REQUEST FOR ORAL BUPRENORPHINE ABOVE 24MG PER DAY:

☐ Prescribed daily dose is consistent with medically accepted prescribing practices and standard of care

☐ Documentation of an evaluation to determine the recommended level of care

☐ Documentation of member is in a substance abuse or behavioral health counseling or treatment program or an addiction recovery program

REQUEST FOR ORAL BUPRENORPHINE ABOVE 24MG PER DAY (CONTINUED):

☐ Member has urine drug screen for drugs with potential for abuse

☐ For members already on buprenorphine, the member has a recent urine drug screen positive for buprenorphine and norbuprenorphine

RENEWAL REQUESTS:

☐ Member has experienced a positive clinical response as evident by:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)