Prior Authorization Request Form for Opioid Dependence Treatment

envolve Pharmacy Solutions

pa health & wellness

FAX this completed form to (877) 386-4695

OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
Office Contact Name:	Group #:
Group 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:_____

Therapeutic Duplication:

If concurrently prescribed a therapeutic duplicate (i.e. another Androgenic Agent or dose different from the agent being requested):

- ☐ is being transitioned from one Androgenic Agent to another with the intent of discontinuing one of the medications
- ☐ has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

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
- ☐ 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 evidenced 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:

Envolve Pharmacy Solutions 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.)