South Country HEALTH ALLIANCE

Opioid Dependence Agents Pharmacy Prior Authorization Form

Confidential Information

Patient Name		Patient DOB
Patient ID Number		
Physician Name		NPI
Phone	Fax	buprenorphine DEA #
Physician Address		
City	State	Zip

Drug Requested: **Preferred agents:**

buprenorphine/naloxone SL tablet ☐2/0.5mg ☐8/2mg

Suboxone® (BRAND) film☐2/0.5mg ☐4/1mg ☐8/2mg ☐12/3mg

If request is for anything other than a preferred product, please provide a medical reason (e.g. Contraindication, hypersensitivity) why the preferred agents can't be used:

Non-Preferred agents: buprenorphine SL tablet ☐2mg ☐8mg

buprenorphine/naloxone (generic) film ☐2/0.5mg ☐4/1mg ☐8/2mg ☐12/3mg

Zubsolv® ☐0.7/0.18mg ☐1.4/0.36mg ☐2.9/0.71mg ☐5.7/1.4mg ☐8.6/2.1mg ☐11.4/2.9mg

Bunavail® ☐2.1-0.3 mg ☐4.2-0.7 mg ☐6.3-1 mg

Directions:

Anticipated Length of Therapy: _____Days _____Months

(Max. of 12 months for initial or renewal request of buprenorphine/naloxone.)

Diagnosis:

☐ Initial Request	☐ Renewal Request
If the criteria are met, buprenorphine/naloxone will be approved for 12 months, or up to a total of 4 weeks of buprenorphine. **Please check all applicable criteria below** *(explain unchecked boxes on 2nd page)*	If the criteria are met, buprenorphine/naloxone will be approved for 12 months. **Please check all applicable criteria below** *(explain unchecked boxes on 2nd page)*

☐ Diagnosis of opioid dependence and/or opioid addiction ☐ The risks of using buprenorphine/naloxone with alcohol or benzodiazepines have been explained to the patient ☐ Provider attests that the member has had a mental health screening and if a mental health disorder is present the member has been referred to or is receiving treatment for the condition ☐ For doses > 16 mg/day of Suboxone or buprenorphine OR > 11.4 mg/day of Zubsolv OR > 8.4 mg/day of Bunavail, explain need for higher dose below ☐ For females of child bearing age, the provider states that a pregnancy test has been completed within 30 days of the request. If positive and the request is not for buprenorphine, an explanation of why the combination product is needed is required.	☐ Consistent use of buprenorphine/naloxone since previous authorization (this will be verified with pharmacy data; if inconsistent use is noted upon database search, then written explanation as to why buprenorphine/naloxone should be continued despite apparent noncompliance would be needed) ☐ Dates of regular (at least every 6 months) urine drug screens that are negative for opiates since previous authorization: Please provide dates: _____ ☐ Documentation must be provided for renewals after the first year that indicate the prescriber has re-evaluated the patient for tapering to a dosage lower than 16 mg/day

Rationale and/or additional information, which may be relevant to the review of this prior authorization request (if criteria listed above are not met, address those issues and explain why buprenorphine/naloxone is still felt to be medically indicated):

Physician Signature	Date

Please return this form to:

PerformRx
200 Stevens Drive
Philadelphia, PA 19113

Or FAX
855-446-7894