

OPIOID USE DISORDER TREATMENTS PRIOR AUTHORIZATION FORM

(form effective 7/10/23)



Keystone First

PERFORMRxSM
Next Generation Pharmacy Benefits

Fax to PerformRxSM at **1-866-497-1387**, or to speak to a representative, call **1-800-588-6767**.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request	Total # of pages:	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:	NPI:	State license #:	
Facility contact name/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:
Directions:	Quantity:	Requested duration:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):
<ul style="list-style-type: none"> • 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 <u>free-of-charge</u> through their prescription drug benefit. 		

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

<p>1. For a NON-PREFERRED SUBLINGUAL buprenorphine product (e.g., film, tablet):</p> <p><input type="checkbox"/> 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.) List preferred medications tried: _____</p> <p>2. For a non-preferred NON-SUBLINGUAL buprenorphine product (e.g., injection):</p> <p><input type="checkbox"/> 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.) List preferred medications tried: _____</p> <p>3. For Lucemyra (lofexidine):</p> <p><input type="checkbox"/> Tried and failed or has a contraindication or an intolerance to clonidine tablet</p> <p>4. For a SUBLINGUAL buprenorphine product ABOVE THE DAILY DOSE LIMIT OF 24 MG of buprenorphine per day:</p> <p><input type="checkbox"/> Is prescribed a daily dose consistent with medically accepted prescribing practices and standards of care</p> <p><input type="checkbox"/> Had an unsatisfactory clinical response (e.g., uncontrolled withdrawal or cravings) at the current quantity limit of 24 mg per day</p> <p><input type="checkbox"/> If already established on buprenorphine, has results of a recent UDS demonstrating compliance with sublingual buprenorphine therapy</p>

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:
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