Request Form for Opioid Dependence Products
Fax to Pharmacy Services at **215-937-5018**, or call **1-800-588-6767**
to speak to a representative. *Form must be completed for processing*.

Keystone First

Member Name: _____ Member ID#: _____
Address: _____ Apt #: _____City: _____ State: _____ Zip Code: _____
Member Birth Date:_____

Physician Name: _____
Buprenorphine DEA #: _____
Phone #: _____ Fax #: _____
Address:_____ Suite #: _____
City: _____ State: _____ Zip Code: _____
Contact Person: _____

GENERIC BUPRENORPHINE/NALOXONE TABLETS ARE THE PREFERRED AGENT

Requested drug/dosage form/strength: _____

Directions: _____

Duration requested: _____

If the request is for any oral agent other than buprenorphine/naloxone tablets, please provide documentation, including medical charts, that member has tried buprenorphine/naloxone sublingual tablets or has a contraindication/hypersensitivity to buprenorphine/naloxone sublingual tablets.

Initial Request:

- Is the member's diagnosis opioid dependence and/or opioid addiction? ☐Yes ☐No*
  *If no, provide the diagnosis _____
- Female members: was a pregnancy test completed within 30 days of request?
  ☐Yes (Circle result: Positive/Negative) ☐No ☐N/A
- Were the risks of using buprenorphine/naloxone with alcohol or benzodiazepines explained to the member?
  ☐Yes ☐No
- Is the request for buprenorphine above 16mg per day (tablets or Suboxone film), Zubsolv above 11.4mg/2.9mg per day or Bunavail film above 8.4mg/1.4mg per day?
  ☐Yes* ☐No
  *If yes, all of the following information is also required:
  - Please provide a medical reason for requesting a higher dose:_____
    _____
  - Was an evaluation completed by a licensed Drug and Alcohol (D&A) provider or single county authority to determine the recommended level of care? ☐Yes* ☐No
    *If yes, date of initial evaluation:_____
  - Is the member participating in counseling with a D&A or behavioral health provider based on the above recommendation? ☐Yes ☐No

Renewal Request:

- Female members: was a pregnancy test completed within 30 days of request?
  ☐Yes (Circle result: Positive/Negative) ☐No ☐N/A
- Were the risks of using buprenorphine/naloxone with alcohol or benzodiazepines explained to the member?
  ☐Yes ☐No
- Is the request for buprenorphine above 16mg per day (tablets or Suboxone film), Zubsolv above 11.4mg/2.9mg per day or

Bunavail film above 8.4mg/1.4mg per day?

☐Yes* ☐No

*If yes, all of the following information is also required:

- Please provide a medical reason for requesting a higher dose:_____
  _____
- Provider confirms consistent member participation in counseling with a D&A or behavioral health provider since the previous authorization: ☐Yes ☐No

  OR

  Provider confirms that the member has completed their program and will continue to participate in a substance abuse counseling, treatment or addictions recovery program: ☐Yes ☐No
- Provider confirms urine or oral fluid drug screens were administered since the previous authorization with the required results as outlined below:
  - Please provide dates: _____
    If the previous authorization was for 6 months, at least 3 drug screens must be administered
    If the previous authorization was for 12 months, at least 6 drug screens must be administered
  - Confirm the results were:
    - Negative for opiates (specifically including oxycodone and fentanyl) ☐Yes ☐No
    - Negative for illicit drugs (with the potential for abuse) ☐Yes ☐No
    - Positive for buprenorphine and norbuprenorphine ☐Yes ☐No

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 treatment is medically necessary.

_____

_____

_____

Deliver to:

☐Member's Home ☐Physician's Office ☐Member's Preferred Pharmacy Name/Phone#):_____

☐ I acknowledge that the member agrees with the pharmacy chosen for delivery of this medication.

Prescriber Signature: _____ **Date**: _____