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

Drug/dosage form and dose: _____ Directions: _____

Duration: _____ Diagnosis: _____

If request is for anything other than buprenorphine/naloxone tablets, please provide a medical reason (e.g. Contraindication, hypersensitivity) why the preferred agent can't be used:_____

_____

Is the prescriber a licensed drug and alcohol specialist? ☐Yes* ☐No
*If yes, please provide practice facility licensed with the Pennsylvania Department of Drug and Alcohol Programs (DDAP):

_____

Initial Requests:

- Member age is greater than or equal to 16 years old? ☐Yes ☐No
- Provider meets all Federal, State, and Local qualifications to prescribe buprenorphine? ☐Yes ☐No
- Member is diagnosed with opioid dependence and/or opioid addiction? ☐Yes ☐No
- Documentation submitted **(member signed copy of contract must be attached)**
  - Member has agreed to treatment contract that includes consequences of violating the contract **(member signed copy of contract must be attached)**? ☐Yes ☐No
- Provider attests to the following:
  - Provider is currently enrolled with the Health Plan, Behavioral Health MCO, or is enrolled in the Medical Assistance Program? ☐Yes ☐No
  - Member has signed consent form authorizing physician to release member information? ☐Yes ☐No
  - Risks of using buprenorphine/naloxone with alcohol or benzodiazepines have been explained to the member ☐Yes ☐No
  - Member had a mental health screening and if co-occurring mental health disorder, member has been referred or is receiving treatment for that condition? ☐Yes ☐No ☐N/A
  - Female members: pregnancy test within 30 days of request? ☐Yes (Positive/Negative/N/A) ☐No
  - Initial evaluation by a licensed Drug and Alcohol (D&A) provider to determine the recommended level of care? ☐Yes* ☐No
    - *If yes, date of initial evaluation: _____
  - Referral to, enrollment into, and/or active participation in a substance abuse or behavioral health treatment program with formal counseling by a D&A provider? ☐Yes ☐No
    - Referral date: _____
    - Name of treatment program: _____
    - Name of counselor: _____
    - Frequency schedule for counseling: _____
- Has the member had more than one (1) prior attempt to treat opiate addiction with buprenorphine in previous 12 months? ☐Yes* ☐No

- *If yes, provider attests to: acknowledgement of previous treatment attempts ☐Yes ☐No
- Provider has completed an assessment indicating the need for buprenorphine ☐Yes ☐No

- Is the request for greater than 16mg/day of Suboxone or buprenorphine, or 11.4/2.8mg/day of Zubsolv? ☐Yes* ☐No
  - *If yes, please provide a reason for requesting a higher dosage. _____

Renewal Requests:

- Provider attests to the following:
  - Provider is currently enrolled with the Health Plan, Behavioral Health MCO, or is enrolled in the Medical Assistance Program? ☐Yes ☐No
- Provider meets all Federal, State, and Local qualifications to prescribe buprenorphine/naloxone? ☐Yes ☐No
- Has the member consistently taken buprenorphine since the previous authorization? ☐Yes ☐No*
  - *If no, please provide an explanation as to why the medication should be continued despite apparent noncompliance: _____
- Provider attests for female members: pregnancy test completed within 30 days of request? ☐Yes (Positive/Negative/N/A) ☐No
- Documentation submitted **(lab copies must be attached*)**:
  - **If previous authorization was for 1 month-ONE drug screen must be provided (urine or oral fluid tests) that are**:
  - **If previous authorization was for 12 months-SIX drug screens must be provided (urine or oral fluid tests) that are:**
    - **Negative for opiates** (specifically including oxycodone and fentanyl)
    - **Negative for illicit drugs** (with the potential for abuse)
    - **Positive for buprenorphine and norbuprenorphine**
  - Provider attests that the risks of using buprenorphine/naloxone with alcohol or benzodiazepines have been explained to the member? ☐Yes ☐No
  - Provider attests to consistent member participation in formal counseling by a licensed behavioral health provider since previous authorization:

    ****NOTE that Narcotics Anonymous or a 12 Step Program is NOT ACCEPTABLE to meet this requirement****
    - Name of treatment program: _____
    - Name of counselor: _____
    - Frequency schedule for counseling: _____
  - Provider attests to ongoing member behavioral health care for co-existing behavioral health disorders? ☐Yes ☐No ☐N/A
  - ***For renewals after the first year:*** provider attests to having reevaluated the member for clinical assessment of effectiveness and dosage lower than 16mg/day of Suboxone or equivalent? ☐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.

_____

_____

_____

Prescriber Signature: _____ **Date**: _____

10/9/2017