

OPIOID USE DISORDER TREATMENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Opioid Use Disorder Treatments** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request total # 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>):

- **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 free-of-charge 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.**

- 1. For a non-preferred SUBLINGUAL buprenorphine product (eg, film, tablet):**
 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.*)
- 2. For a non-preferred NON-SUBLINGUAL buprenorphine product (eg, injection):**
 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.*)
- 3. For Lucemyra (lofexidine):**
 Tried and failed or has a contraindication or an intolerance to clonidine tablet

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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