

## 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:  |                  |
| Member name:  |      |                      | City/State/Zip:  |                  |
| Member 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 866-240-3712**

|                       |       |
|-----------------------|-------|
| Prescriber Signature: | Date: |
|-----------------------|-------|

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