AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Opioid Dependence Therapy Agents

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___270 days ___365 days

Clinical Information

For Coverage of Buprenorphine/Naloxone SL Films, and Zubsolv:

1. Has the beneficiary failed one preferred drug? Yes___ No___
   Please list: _____
   1a. __Allergic reaction 1b. __ Drug-to-drug interaction. Please describe reaction: _____
   _____
2. __Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____
   _____
3. __Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
   Please provide clinical information: _____
4. __Age-specific indications. Please give patient age and explain: _____
   _____
5. __Unique clinical indication supported by FDA approval or peer-reviewed literature. Please explain and provide a general reference: _____
6. __Unacceptable clinical risk associated with therapeutic change. Please explain: _____
   _____

For Coverage of Buprenorphine Sublingual Tablets:

7. Does the Beneficiary have a diagnosis of Opioid Dependence? Yes___ No___
8. Is the beneficiary unable to use Suboxone Film? Yes___ No___
   If Yes, please specify one or more of the following conditions:
   __ Beneficiary is pregnant: Please Provide Estimated Due Date: _____ **Max Length of Therapy is 270 Days**
   __ Beneficiary is breastfeeding. **Max Length of Therapy is 60 Days (can be renewed)**
   __ Beneficiary has an allergy to naloxone (rashes, hives, pruritis, bronchospasm, angioneurotic edema, and anaphylactic shock). **Max Length of Therapy is 365 Days**
   __ Other condition. Please list: _____
9. Has the prescriber reviewed the controlled substances reporting system database prior to writing the prescription to ensure that concomitant opioid use is not occurring? Yes___ No___
10. Is the maximum daily dose less than or equal to 32 mg/day? Yes___ No___

For Coverage of Lucemyra Tablets:

11. Does the Beneficiary have a diagnosis of opioid withdrawal symptoms? Yes___ No___ (trial and failure of preferreds are not required)

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406