

PROBUPHINE (buprenorphine implant) PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Opioid Dependence Treatments and Quantity Limits/Daily Dose Limits are accessible on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharm_acy.aspx?strip=true&style=OneGeisinger

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total # pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		DATA 2000 waiver DEA number:	
Facility contact/phone:		NPI:	State license #:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: Probuphine 74.2 mg implant	Quantity: <input type="checkbox"/> 1 implant kit (contains 4 implants) <input type="checkbox"/> other:
Requested duration: <input type="checkbox"/> 6 months <input type="checkbox"/> other:	Dx code (<i>required</i>):
Diagnosis (<i>submit documentation</i>):	
1. Is the beneficiary being treated for a diagnosis of opioid use disorder?	<input type="checkbox"/> Yes – <i>Submit documentation of diagnosis.</i> <input type="checkbox"/> No – <i>Submit medical literature supporting the use of the requested agent for the beneficiary's diagnosis.</i>
2. Did the prescriber or prescriber's delegate search the PDMP to review the beneficiary's controlled substance prescription history before issuing this prescription for Probuphine?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
INITIAL requests	
1. Has the beneficiary achieved and sustained prolonged clinical stability on transmucosal buprenorphine?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>
2. Is the beneficiary stable and on no more than 8 mg per day of oral buprenorphine for at least the last three (3) months without any need for supplemental dosing or adjustments?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>

Please submit to PromptPA <https://ghp.promptpa.com> OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation

Prescriber Signature:	Date:
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