GHP Family Pharmacy Customer Service
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Geisinger
GHP Family

OPIOID DEPENDENCE TREATMENTS (ORAL) PRIOR AUTHORIZATION FORM *(form effective 1/1/20)*

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

☐ New request ☐ Renewal request	total # pages: ________	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		DATA 2000 waiver DEA number:	
Name of facility contact:		NPI:	State license #:
Facility's phone number:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:
Directions:	Qty:	Requested duration:
Diagnosis (*submit documentation*):		DX code (*required*):

1. Did the prescriber or prescriber's delegate search the PDMP to review the beneficiary's controlled substance prescription history before issuing this prescription for the requested medication?
   ☐ Yes ☐ No — *Submit documentation.*
2. ***For non-preferred oral buprenorphine requests***, does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred oral buprenorphine agents? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred agents.*
   ☐ Yes ☐ No — *Submit documentation for all agents tried.*
3. ***For requests for an oral buprenorphine agent that does not contain naloxone***, do any of the following apply to the beneficiary? Check all that apply.
   ☐ beneficiary is pregnant ☐ the requested agent is being used for induction therapy
   ☐ beneficiary is breastfeeding
   ☐ Yes ☐ No — *Submit documentation.*
4. Does the request exceed the daily dose limit of 16 mg of buprenorphine per day?
   ☐ Yes – *Submit documentation supporting requested dose and* ***continue to question 6***.
   ☐ No – ***Skip to question 7.***
5. ***For requests above the daily dose limit of 16 mg of buprenorphine per day***, check all of the following that apply to the beneficiary, submit documentation for each, *and* ***continue to question 7***.
   ☐ Has an initial or scheduled evaluation by a licensed D&A provider or Single County Authority (SCA) for the determination of level of care
   ☐ Is participating in a program with a licensed D&A or behavioral health provider at the recommended level of care
   ☐ Is participating in a substance abuse or behavioral health counseling or treatment program or an addictions recovery program
   ☐ Has results of a recent UDS (including licit and illicit drugs with abuse potential) demonstrating compliance with oral buprenorphine therapy
   Date of last UDS Test: ____________________
6. Is the beneficiary taking a benzodiazepine or other CNS depressant?
   ☐ Yes – *Submit beneficiary's medication list and* ***continue to question 8.***
   ☐ No – *Submit beneficiary's medication list and send request and documentation to GHP.*
7. ***For a beneficiary who is taking a benzodiazepine (BZD) or other CNS depressant in addition to the requested buprenorphine agent***, check all of the following that apply to the beneficiary and submit documentation for each.
   ☐ Was educated about the serious risks of concomitant use of buprenorphine with the BZD or other CNS depressant
   ☐ Has a plan in place to taper the BZD or other CNS depressant
   ☐ Is receiving the BZD or other CNS depressant for anxiety or insomnia, and this diagnosis was verified
   ☐ Is receiving the BZD or other CNS depressant for anxiety or insomnia, and other treatment options for the diagnosis were considered
   Concomitant use of buprenorphine with the BZD or other CNS depressant is medically necessary
   ☐ Has results of urine or blood screening
8. ***For Lucemyra requests***, does the beneficiary have a history of trial and failure, contraindication, or intolerance of clonidine tablet?
   ☐ Yes ☐ No — *Submit documentation.*

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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