# Non-preferred Buprenorphine/Naloxone Prior Authorization Request Form

## Medical Reason Preferred Formulary Buprenorphine Products Can’t Be Used

- [ ] Medical reason preferred formulary buprenorphine products can’t be used: ________________________________________________________________________________________________

## Date and Results of Most Recent Lab Screen

- [ ] Date and results of most recent lab screen (must be within 28 days of PA request), Screen date: _________________
- [ ] Drugs present:  
  - [ ] Buprenorphine  
  - [ ] Other opiates  
  - [ ] Other controlled substances (list below)
- [ ] If buprenorphine not present and opiates or other controlled substances present how is this being addressed?
  - ________________________________________________________________________________________________

## Patient Has Been Adherent to Buprenorphine or Buprenorphine/Naloxone Therapy

- [ ] Patient has been adherent to buprenorphine or buprenorphine/naloxone therapy:  
  - [ ] Yes  
  - [ ] No
- [ ] If “No” how is this being addressed:
  - ________________________________________________________________________________________________

## Patient Has Been Referred to and is Actively Involved in Formal Counseling with a Licensed Behavioral Health Provider

- [ ] Patient has been referred to and is actively involved in formal counseling with a licensed behavioral health provider  
  - [ ] Yes  
  - [ ] No
  - [ ] Name of counselor and/or facility:
- [ ] If “No” how is this being addressed:
  - ________________________________________________________________________________________________

## Request for Expedited Review

- [ ] REQUEST FOR EXPEDITED REVIEW [24 HOURS]
  - BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING FOR THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER’S ABILITY TO REGAIN MAXIMUM FUNCTION
Instructions for completing the form

1. Submit a separate form for each medication.

2. Complete ALL information on the form. 
   NOTE: The prescribing physician should, in most cases, complete the form.

3. Please be sure to provide the physician address in a legible format, as it is required for notification.

4. Once form is completed, mail or fax to:

   Geisinger Health Plan
   Attn: Pharmacy Department 32-45
   100 N. Academy Avenue
   Danville, PA 17822
   Fax: 570-300-2122

Non-preferred Buprenorphine/Naloxone Prior Authorization Clinical Management Procedures*

The Health Plan's Pharmacy Department maintains a process by which Health Care Providers can request precertification for a non-preferred buprenorphine/naloxone product

Buprenorphine/naloxone requests will be evaluated, and a determination of coverage made utilizing the following criteria:

1. Member's eligibility to receive requested services (enrollment in the plan, prescription drug coverage, specific exclusions in Member's contract)

2. Specific criteria listed on the form

Please note that initial authorization will be for 3 months and subsequent authorizations will be for 12 months.

A quantity limit of a 34-day supply per fill will apply.

* Please refer to the Health Plan's Provider Guide and formularies for further information.

Please note that the prior authorization process is an independent process and is not in conjunction with the Specialty Pharmacy Drug Program.

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1 Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.