United Healthcare Community Plan

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
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. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ 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 breast feeding 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 1-866-940-7328

Pharmacy PA Call Center: 1-855-258-1593