BlueCross BlueShield of North Carolina | HealthyBlue

Opioid Dependence Therapy Agents Prior Authorization Form

Member information		
1. Member last name:	2. Member first name:	
3. Member ID #:	4. Member date of birth:	5. Member gender:
Prescriber information		
6. Prescribing provider NPI #:		
7. Prescriber 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 ☐ 365 days ☐ Other: ___________________		
Clinical information		
For coverage of Buprenorphine/Naloxone SL Films, and Zubsolv:		
1. Has the member 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 member circumstance as a contraindication to preferred drug(s). Please provide clinical information:		
4. ☐ Age specific indications. Please give member 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 member have a diagnosis of opioid dependence? ☐ Yes ☐ No		
8. Is the member unable to use suboxone film? ☐ Yes ☐ No		
If **yes**, please specify one or more of the following conditions: ☐ Member is pregnant: Please provide estimated due date: ____________ **Max length of therapy is 270 days.** ☐ Member is breast feeding **Max length of therapy is 60 days (can be renewed).** ☐ Member 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)		

https://provider.healthybluenc.com

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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 **844-376-2318**.
Healthy Blue Pharmacy PA Call Center: **844-594-5072**