



**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.**)

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Pharmacy PA Call Center: 1-866-799-5318



- 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

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.

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