Request Form for Opioid Dependence Agents
Fax to PerformRx at **855-811-9332**, or to speak to a Representative call **888-602-3741**.
Form must be completed for processing.

AmeriHealth Caritas District of Columbia

Member Name: _____ Member ID#: _____
Birth Date: _____

Physician Name: _____
Buprenorphine DEA #: _____
Phone #: _____ Fax #: _____
Address: _____ Suite #: _____
City: _____ State: _____ Zip Code: _____
Contact Person: _____

GENERIC BUPRENORPHINE/NALOXONE TABLETS ARE THE PREFERRED AGENT

Drug and Dose: _____ Directions: _____

Duration: _____ Diagnosis: _____

IF THE REQUEST IS FOR ANY OTHER AGENT OTHER THAN THE GENERIC FORMULATION OF SUBOXONE TABLETS, PLEASE PROVIDE MEDICAL REASON (e.g. pregnancy, contraindication) AS TO WHY MEMBER IS UNABLE TO USE THE PREFERRED AGENT BELOW:

_____

Initial Requests:

- Member age is greater than or equal to 16 years old? Yes No
- Prescriber meets all Federal, State, and Local qualifications to prescribe buprenorphine? Yes No
- Member is diagnosed with opioid dependence and/or opioid addiction? Yes No
- Provider has referred member for ongoing support and appropriate substance abuse counseling? Yes No
    - Referral date: _____
    - Name of Counselor/Program: _____
    - Member is unable or unwilling to participate in counseling? Yes* No

      *If Yes, documentation is REQUIRED including and explanation and rationale for maintaining the member on the drug treatment program.
- Is the request for greater than 24mg/day of buprenorphine/naloxone or buprenorphine or equivalent? Yes* No

  *If yes, please provide documentation of the clinical and physiological characteristics warranting a higher dose: _____

  _____

  _____

  _____

Renewal Requests:

- Prescriber meets all Federal, State, and Local qualifications to prescribe buprenorphine? Yes No
- **Documentation must be submitted for the following:**
    - Documentation of consistent participation in formal counseling since previous authorization:
        - Name of treatment program: _____
        - Name of counselor: _____
        - Frequency schedule for counseling: _____

- Date of program completion (if applicable): _____
- Member is unable or unwilling to participate in counseling? Yes* No

  *If Yes, documentation is REQUIRED including and explanation and rationale for maintaining the member on the drug treatment program.

- Is the request for greater than 24mg/day of buprenorphine/naloxone or buprenorphine or equivalent? Yes* No

  *If yes, please provide documentation of the clinical and physiological characteristics warranting a higher dose: _____

  _____

  _____

  _____

- Rationale and/or additional information which may be relevant to the review of this prior authorization request. If criteria listed above are not met, address those issues and explain why treatment is medically necessary.

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Prescriber Signature: _____ **Date**: _____