Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Opioid Use Disorder Treatments

A. Prescriptions That Require Prior Authorization

Prescriptions for Opioid Use Disorder Treatments that meet any of the following conditions must be prior authorized:

1. A non-preferred Opioid Use Disorder Treatment. See the Preferred Drug List (PDL) for the list of preferred Opioid Use Disorder Treatments at: https://papdl.com/preferred-drug-list.

   REMINDER: A prescription for a benzodiazepine, opioid analgesic, controlled substance sedative hypnotic, or carisoprodol requires prior authorization when a beneficiary has a concurrent prescription for a buprenorphine Opioid Use Disorder Treatment. Refer to the specific individual handbook chapters (e.g., Analgesics, Opioid Long-Acting, Analgesics, Opioid Short-Acting, Anticonvulsants, Anxiolytics, Skeletal Muscle Relaxants, Sedative Hypnotics) for corresponding prior authorization guidelines.

   REMINDER: A prescription for an opioid analgesic requires prior authorization when a beneficiary has a concurrent prescription for Vivitrol.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Opioid Use Disorder Treatment, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Opioid Use Disorder Treatment for treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

2. For Lucemyra (lofexidine), is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. For a non-preferred Opioid Use Disorder Treatment, **one** of the following:

   a. For a sublingual buprenorphine Opioid Use Disorder Treatment, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred sublingual buprenorphine Opioid Use Disorder Treatments,
   b. For an alpha-2 adrenergic agonist Opioid Use Disorder Treatment, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred alpha-2 adrenergic agonist Opioid Use Disorder Treatments,
   c. For a non-sublingual buprenorphine Opioid Use Disorder Treatment, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred non-sublingual buprenorphine Opioid Use Disorder Treatments;

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NOTE: If the beneficiary does not meet the clinical review guidelines and quantity limit guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Opioid Use Disorder Treatment. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

Requests for prior authorization of Lucemyra (lofexidine) will be approved for a dose and duration of therapy consistent with the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

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OPIOID USE DISORDER TREATMENTS PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
Facility contact name/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:
Directions:	Quantity:	Requested duration:
Diagnosis *(submit documentation)*:		Dx code (*required*):

- **Pennsylvania law requires prescribers to query the PA PDMP each time a patient is prescribed an opioid drug product or benzodiazepine.**
- **Naloxone is available at Pennsylvania pharmacies via standing order from the Secretary of the Department of Health. Pennsylvania Medical Assistance beneficiaries may obtain naloxone free-of-charge through their prescription drug benefit.**

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

1. **For a NON-PREFERRED SUBLINGUAL buprenorphine product (eg, film, tablet):**
   ☐Tried and failed or has a contraindication or an intolerance to the preferred SUBLINGUAL buprenorphine Opioid Use Disorder Treatments (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*
2. **For a non-preferred NON-SUBLINGUAL buprenorphine product (eg, injection):**
   ☐Tried and failed or has a contraindication or an intolerance to the preferred NON-SUBLINGUAL buprenorphine Opioid Use Disorder Treatments (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*
3. **For Lucemyra (lofexidine):**
   ☐Tried and failed or has a contraindication or an intolerance to clonidine tablet

PLEASE FAX COMPLETED FORM TO HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	**Date**: