Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Opioid Dependence Therapy Agents

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
3. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. Length of Therapy: ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days

Clinical Information

For Coverage of Buprenorphine/Naloxone SL Films, and Zubsolv:

1. Has the member failed one preferred drug? ☐ **Yes** ☐ **No** Please List: _____
   a. Was the failure due to an allergic reaction? ☐ **Yes** ☐ **No**
   b. Was the failure due to a drug-to-drug interaction? ☐ **Yes** ☐ **No**
   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 member have a diagnosis of opioid withdrawal symptoms? ☐ **Yes** ☐ **No** (trial and failure of preferred 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.