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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Narcan (naloxone) Nasal Spray

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk: 1-800-454-3730

1. PATIENT INFORMATION	2. PHYSICIAN INFORMATION
Patient name: ______	Prescribing physician: ______
Patient ID #: ______	Physician address: ______
Patient DOB: ______	Physician phone #: ______
Date of Rx: ______	Physician fax #: ______
Patient phone #: ______	Physician specialty: ______
Patient email address: ______	Physician DEA: ______
	Physician NPI #: ______
	Physician email address: ______

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Narcan (naloxone) nasal spray	______	______	Specify: ______

7. DIAGNOSIS: ______

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient and MAY AFFECT THE OUTCOME of this request.

Prior authorization is required for a patient requiring more than two doses of Narcan (naloxone) nasal spray per 365 days. Requests for quantities greater than two doses per 365 days will be considered under the following conditions: 1) Documentation is provided indicating why patient needs additional doses of Narcan (naloxone) nasal spray (accidental overdose, intentional overdose, other reason), 2) Narcan (naloxone) nasal spray is to be used solely for the patient it is prescribed for, 3) The patient is receiving an opioid as verified in pharmacy claims, 4) The patient has been re-educated on opioid overdose prevention, 5) Documentation is provided on the steps taken to decrease the chance of opioid overdose again, and 6) A treatment plan is included documenting a plan to lower the opioid dose.

Most recent fill date:______ Most recent date medication used:______

Medical necessity for exceeding quantity limit:

☐ Intentional overdose ☐ Accidental overdose ☐ Other reason:______

Will Narcan be used solely for the patient it is prescribed for? ☐ Yes ☐ No

Is patient currently receiving an opioid as verified in pharmacy claims? ☐ No ☐ Yes, provide drug name and most current fill date:______

Has patient been reeducated on opioid overdose prevention? ☐ No ☐ Yes, date provided: ______

Provide documentation on the steps taken to decrease the chance of opioid overdose again: ______

______

Provide treatment plan to lower opioid dose:______

______

Attach lab results and other documentation as necessary.

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Patient name: ______________________________ **Patient ID #:** ______________________________

9. PHYSICIAN SIGNATURE

______________________________ ______________________________

Prescriber or authorized signature Date

Prior authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete, and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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