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Buprenorphine/Naloxone Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
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**
_____	_____	_____	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 (PA) is required for transmucosal buprenorphine or buprenorphine/naloxone. Requests will be considered for FDA approved dosing, including induction and maintenance dose. Requests for doses above 24 mg per day will not be considered. Initial requests will be considered for up to three months. Requests for maintenance doses above 16 mg per day will not be considered on a long-term basis. After the initial three month PA, renewal requests for doses ≤ 16mg per day may be considered for 12-month renewals as long as the member meets all other PA criteria. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. Requests for surgically implanted buprenorphine or buprenorphine depot injections products will not be considered through the pharmacy benefit and should be directed to the member's medical benefit. Payment will be considered when the following is met:

1. Patient has a diagnosis of opioid dependence and meets the FDA-approved age
2. Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has an "X" DEA number (provide X DEA number)
3. Documentation the Iowa Prescription Monitoring Program website has been reviewed for the patient's use of controlled substances
4. Documentation is provided that transmucosal buprenorphine will not be used concomitantly with the buprenorphine implant or depot injection
5. Requests for single ingredient buprenorphine will only be considered for pregnant patients

Requests for renewal must include:

1. Documentation the Iowa Prescription Monitoring Program (PMP) website has been reviewed for the patient's use of controlled substances since the last PA request
2. Patient does not have documentation of concomitant use of an opioid or tramadol with the requested buprenorphine product as seen in paid pharmacy claims
3. Patient is not using transmucosal buprenorphine with buprenorphine implant or depot injection

Preferred

☐ Buprenorphine/Naloxone SL tabs

☐ Buprenorphine (Please verify patient is pregnant) ☐ Yes ☐ No

Nonpreferred

☐ Bunavail

☐ Buprenorphine/Naloxone SL Film

☐ Suboxone SL Film

☐ Zubsolv

Initial requests

Prescriber meets qualifications to prescribe and treat opioid dependence and possess "X" DEA number:
☐ Yes ☐ No X DEA number: _____

Is patient using transmucosal buprenorphine with buprenorphine implant or depot injection? ☐ Yes ☐ No

Documentation the Iowa PMP website has been reviewed for the patient's use of controlled substances. ☐ Yes ☐ No
Date reviewed: _____

Renewal requests

Documentation the Iowa PMP website has been reviewed for the patient's use of controlled substances since the last prior authorization request. ☐ Yes ☐ No Date reviewed: _____

Does patient have concomitant use of an opioid or tramadol with the requested buprenorphine product?
☐ Yes ☐ No

Is patient using transmucosal buprenorphine with buprenorphine implant or depot injection? ☐ Yes ☐ No

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.