SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Oral Buprenorphine Products

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Oral Buprenorphine Products do not require a prior authorization if:

- It is for a preferred product Suboxone® SL film or buprenorphine/naloxone tablets;
- If the member is 16 years of age or older
- If the prescribed dosage is 24mg/day or less

Per the Board of Medicine reg 18VAC85-21-150: DOSES GREATER THAN 24 MG/DAY WILL DENY.

Maximum Quantities for Dose Optimization (Preferred Drugs)

- ❑ buprenorphine SL tab 2mg; 3/day
- ❑ buprenorphine/naloxone SL tab 2mg/0.5mg; 3/day
- ❑ Suboxone® SL film 2mg/0.5mg; 3/day
- ❑ Suboxone® SL film 8mg/2mg; 3/day
- ❑ buprenorphine SL tab 8mg; 2/day
- ❑ buprenorphine/naloxone SL tab 8mg/2mg; 3/day
- ❑ Suboxone® SL film 4mg/1mg; 1/day
- ❑ Suboxone® SL film 12mg/3mg; 2/day

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Maximum Quantities for Dose Optimization (Non-Preferred Drugs)

- ❑ buprenorphine/naloxone SL film 2mg/0.5mg; 3/day
- ❑ buprenorphine/naloxone SL film 4mg/1mg; 1/day
- ❑ buprenorphine/naloxone SL film 8mg/2mg; 3/day
- ❑ Zubsolv™ SL tab 0.7mg/0.18mg; 2/day
- ❑ Zubsolv™ SL tab 1.4mg/0.36mg; 2/day
- ❑ Zubsolv™ SL tab 2.9mg/0.71mg; 2/day
- ❑ Zubsolv™ SL tab 5.7mg/1.4mg; 2/day
- ❑ Zubsolv™ SL tab 8.6mg/2.1mg; 2/day
- ❑ Zubsolv™ SL tab 11.4mg/2.9mg; 2/day

CLINCIAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Length of Authorization: 3 Months (Initial Authorization); 6 months (Maintenance)

1. Your member's pregnancy has been confirmed by a positive laboratory test?

   ❑ Yes ❑ No

   Buprenorphine mono-product will only be covered for pregnant women for a maximum of 10 months.

   Document expected date of delivery: _____

   (**IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED** unless a non-preferred/non-formulary drug is prescribed. See Q4 if non-formulary drug is prescribed.)

2. Does member meet criteria for a diagnosis of Opioid Use Disorder (defined by DSM 5: https://pcssnow.org/resource/opioid-use-disorder-opioid-addiction/)? ❑ Yes ❑ No
3. Is the member 16 years of age or older? ❑ Yes ❑ No
4. Non-Preferred agents require documentation as to why the member cannot be prescribed a preferred agent. Include details and a completed FDA MedWatch Form (https://www.accessdata.fda.gov/scripts/medwatch/index.cfm) is required to be attached for adverse reactions to combination products.

   _____

   _____

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.