

**IMPORTANT NOTICE:**  
 New Prior Authorization Procedure for requesting  
 Buprenorphine and Buprenorphine/Naloxone Products for  
Substance Abuse Treatment Center (HUB) Providers

December 29<sup>th</sup>, 2014

Dear Hub Provider:

This letter is to notify you of an important change in the prior authorization (PA) process for requesting buprenorphine products. The DVHA's Substance Abuse Unit will no longer be processing these requests. **Effective January 1<sup>st</sup>, 2015, the DVHA's new Prescription Benefit Management (PBM) vendor, Goold Health Systems, Inc (GHS) will be reviewing all requests from the OTP Hub providers.**

GHS replaces Catamaran as DVHA's PBM, and a new provider call center located in South Burlington will manage the PA's. The new call center is fully staffed from 7:30am-6:30pm Monday through Friday, and Saturday 8am-2pm. The Call Center is available 24 hours a day, seven days a week via on-call support as well. **The GHS Call Center phone number is 1-844-679-5363, and the fax number for PA forms is 1-844-679-5366.** Attached to this communication is a new PA form with a new facsimile number. Beginning on January 1<sup>st</sup>, this form can also be found on the DVHA website at: <http://dvha.vermont.gov/for-providers/pharmacy-prior-authorization-request-forms>

**Prior Authorization Requirements:**

DVHA's preferred buprenorphine/naloxone formulation is **Suboxone® Film** and the maximum dose that can be approved without prior authorization is 16MG per day. Requests for buprenorphine monotherapy, Suboxone® tablets, doses of any agent higher than 16MG per day, will only be approved on an exception basis. See criteria below:

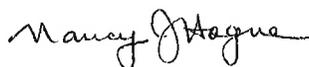
<b>HUBS: Opiate Dependency</b> <i>(Length of Authorization: Up to one year)</i>	
<b>PREFERRED DRUGS (No PA Required for 16mg or less)</b>	<b>NON-PREFERRED DRUGS (PA Required for all doses)</b>
SUBOXONE® sublingual FILM (buprenorphine/naloxone)	buprenorphine sublingual TABLET (formerly Subutex®)
	buprenorphine/naloxone (formerly Suboxone®) sublingual TABLET
<b><i>(Maximum Daily Dose = 16 mg/day without PA)</i></b>	<b><i>(PA Required for all doses)</i></b>
As a reminder, Suboxone® when prescribed for opiate dependency (its only FDA approved indication) is designed to be dosed no more than once daily. Daily doses should be made up of the fewest number of dosage units (now easier with 4 different film strengths – 2/0.5, 4/1, 8/2 and 12/3). Films should never be divided as the child protection is then lost from the remainder of the dose.	

**IMPORTANT NOTE: Please use the attached PA form for ALL ADAP UNINSURED patients and Fax to GHS Call Center. The DVHA Medical Team will be completing the prior authorization reviews for the uninsured populations.**

We greatly appreciate your understanding and cooperation with these efforts. If you have questions related to this notice, please feel free to contact the DVHA Pharmacy Unit at 1-802-879-5900, or your HP Provider Relations Representative at 1-800-925-1706 or 802-878-7871.

Thank you for your continued support of the State of Vermont's pharmacy programs.

Sincerely,



Nancy Hogue, Pharm.D.  
 Director of Pharmacy Services

## ~ HUB (OTP) BUPRENORPHINE Prior Authorization Form ~

All requests for Suboxone® Film > 16MG, Suboxone® Tablets (all doses) and Buprenorphine monotherapy in women who are pregnant or who are breastfeeding a morphine or methadone-dependent baby must be reviewed by the GHS Clinical Call Center. Documentation must accompany this form.

Submit request via Fax (only): (844)-679-5366

**Prescribing physician:**Name: \_\_\_\_\_  
NPI #: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Fax #: \_\_\_\_\_  
Address: \_\_\_\_\_**Beneficiary:**Name: \_\_\_\_\_  
Medicaid ID #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Date of Admission to HUB: \_\_\_\_\_CHECK HERE IF PATIENT IS ADAP UNINSURED Request is from the following HUB location: \_\_\_\_\_ / \_\_\_\_\_  
Name NPI

Contact Person at HUB (OTP): \_\_\_\_\_

► Please choose the requested formulation, check that you have provided a clinical note/letter, and complete any other required information.

 **Suboxone® Film > 16 mg**

Dose per day requested: \_\_\_\_\_mg

 **Suboxone® Tablets**

Dose per day requested: \_\_\_\_\_mg

 Clinical note/letter from prescriber that documents the prescriber's clinical rationale for requesting Suboxone® tablets or Suboxone® Film > 16MG (REQUIRED) is attached. **Buprenorphine (mono formulation) – Females Only**

Dose per day requested: \_\_\_\_\_mg

 Pregnancy

DUE DATE: \_\_\_\_\_

 Pregnancy test/ultrasound result/lab attached (REQUIRED) Breastfeeding a morphine or methadone-dependent baby (baby is being administered morphine or methadone for opiate withdrawal symptoms) Clinical note/letter from a pediatrician/neonatologist that documents that the member is breastfeeding a morphine or methadone dependent baby (REQUIRED) is attached. Using buprenorphine mono to switch from methadone to Suboxone®

Dates buprenorphine mono will be administered: \_\_\_\_\_

**Please Note: All requests other than for Suboxone Film <=16mg must be directed to GHS at**

**Phone: (844)-679-5363 or Fax: (844)-679-5366**

Prescriber Signature: \_\_\_\_\_ (stamps not acceptable) Date of request: \_\_\_\_\_