

## ~BUPRENORPHINE ~

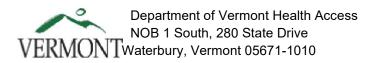
## **Prior Authorization Request Form (Spokes/OBOTS)**

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety, sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare help desk at 1-844-679-5363.

## Submit request via Fax: 1-844-679-5366

Prescribing physicia		Beneficiary: Name:				
Physician NDI:		Medicaid ID#:				
		Date of Birth:	Sex:			
Phone#:		Pharmacy Name				
		Pharmacy NPI:			=	
Address:		Pharmacy NPI:Pharmacy Fax:Pharmacy Fax:			_	
Contact Person at C	Office:	,	,		_	
Contact Forcer at C						
Dose:	Dosage Form (e.g. Film)	:Frequency:	(recomn	nended o	nce daily)	
Does the prescribe	er signing this form have a DATA 2	000 waiver ID {"X-DEA license")?		□Yes	□No	
Vermont Prescription Monitoring System (VPMS) has been queried.			□Yes	□No		
Is this a reduction in total daily dose? (Prior Authorization will be approved for a decrease in total daily dose, there will not be a need to proceed any further with this form)					□ No	
Is documentation detailing medical necessity for requested dosing regimen included for all requests exceeding quantity limits or daily dose > 16mg?				□Yes	□No	
	ne" for ALL prescriptions MAY BE s parmacy you would like member to	selected but is no longer required. be locked in: (Optional)				
If this request is fo	or Buprenorphine {formerly Subu	utex®), please answer the following qu	estions:			
Is the member pregnant? Provide copy of positive pregnancy test and anticipated delivery date.			□Yes	□No		
*Per ASAM / ACOG guidelines pregnancy is no longer considered an absolute indication for buprenorphine (Subutex®).				Delive	ry Date:	
In your medical opinion, is the member experiencing adverse reactions or intolerance to the combination products during pregnancy that cannot be resolved or mitigated through alternative efforts?		□Yes	□No			
*For pregnant won	nen approval for buprenorphine (Su	ubutex®) will expire 90 days postpartur	n.			
*Other requests for <b>Buprenorphine {formerly Subutex®)</b> or nonpreferred formulations must include clinical documentation detailing a provider-observed reaction severe enough to require discontinuation of BOTH preferred buprenorphine/naloxone combination products. Documentation of measures tried to mitigate/manage symptoms is required.						
*If multiple doses	are being requested to facilitate TIT	FRATION, please indicated in clinical no	otes			
that this should be of the dose. In add	e avoided, particularly if there are dition, the manufacturer does not r	escriber discretion is not prohibited by children in the home, as the child pro- recommend splitting the film, and there	otection is then lo e is a lack of data	ost for the on unifori	remainder m potency.	
	upported in your medical records. I also underst	urate and complete. That the request is medically ne and that any misrepresentations or concealment of a				
Prescriber Signatu	re:	XDEA License#:	Date of req	uest:		
Last Updated: 12/20						

CHANGE HEALTHCARE



## ~BUPRENORPHINE Safety & Compliance Checklist~

The checklist is provided to verify providers are following the established minimum requirements for office based opioid treatment including proper prescribing, monitoring, and safety as pursuant to Vermont State Rule 18 V.S.A. § 4752 and Act 195§14 of 2013. MAT Rule.Final Adopted.September 2021 .pdf (healthvermont.gov). It is also intended to ensure that both OUD and the management of acute and chronic pain in the setting of OUD are managed in accordance with state and national guidelines. The guidelines DVHA has chosen to reference and align with include the 2020 ASAM Guidelines and 2021 DVHA Guidelines relating to MAT and treatment of OUD.

The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder – 2020 Focused Update VERMONT SUBSTANCE USE DISORDER OFFICE BASED OPIOID TREATMENT GUIDELINES

VERMONT SUBSTANCE USE DISORDER OFFICE BASED OFFICIDITIES	ATMENT GOIDELINES						
Please select all applicable diagnoses for:	elect all applicable diagnoses for:		□Chronic Pain				
*Note Suboxone is not FDA approved for alleviation of pain without SUD							
Both ASAM and DVHA Guidelines recommend monitoring for medication d To ensure patient and public safety, Vermont State Rules governing MAT re Examples used for monitoring include routine toxicology screens, medication	equire diversion monitoring practi						
Have random toxicological screens (Urine drug screen) been routinely used submit the results of the 3 most recent.)	for this patient? (If yes please	□Yes	3	□No			
Have random medication counts been routinely used for this patient? (If yes 3 most recent.)	s please submit the results of the	□Yes	5	□No			
If the answer to one or both of the above safety questions is NO, or if the passibility submit results of any other monitoring practices and/or protocol for monitori							
NOTE: The results of monitoring practices will <b>NOT</b> be used to make a detencessity, but rather as a verification of monitoring protocols.							
For patients with dual diagnosis of pain:							
Please list the diagnosis for pain condition being managed, if applicable:							
Please list the duration of anticipated treatment dose:							
ASAM Guidelines recommend trials of other non-opioid medications and pain management modalities prior to increasing the buprenorphine dose for pain. Have other medications and modalities been tried? Such treatments may include, but are not limited to: NSAID/Acetaminophen							
If Yes, please list:							
If No, please indicate clinical rationale:							
If this is a dose increase request for chronic pain, has the patient's PCP be- been referred to a specialist for appropriate management of the pain condit		□Yes	□ No	□ N/A			
Per ASAM Guidelines: "Increasing the daily dose of buprenorphine by 20–25% and pain."	splitting it into 3–4 doses can often a	adequate	ly addre	ss acute			
Has split dosing (multiple daily administrations) on current dose been trialed	d for pain control?	□Yes	□No	□ N/A			
Does the dose increase for acute pain amount to greater than 20-25% daily dose? *If yes, please provide clinical rationale			□No	□ N/A			
In those treated for <b>acute pain</b> , is there a provider plan to taper dose down (If yes, please submit the taper plan with clinical documentation)	to minimal effective dosage?	□Yes	□No	□ N/A			
By completing this form, I hereby certify that the above request is true, accurate and complete. That the rec and is clinically supported in your medical records. I also understand that any misrepresentations or conce							

Prescriber Signature: XDEA License#: Date of request:

