Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~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 physician:
Name: _____
Physician NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
Name: _____
Medicaid ID#: _____
Date of Birth: _____ Sex: _____
Pharmacy Name _____
Pharmacy NPI: _____
Pharmacy Phone: _____ Pharmacy Fax: _____

Dose: _____ Dosage Form (e.g. Film): _____ Frequency: _____ (recommended once daily)

Does the prescriber signing this form have a DATA 2000 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)	☐Yes	☐ No
Is documentation detailing medical necessity for requested dosing regimen included for all requests exceeding quantity limits or daily dose > 16mg?	☐Yes	☐ No
A "Pharmacy Home" for ALL prescriptions MAY BE selected but is no longer required. Please indicate pharmacy you would like member to be locked in: (Optional) _____		
If this request is for **Buprenorphine {formerly Subutex®)**, please answer the following questions:		
Is the member pregnant? Provide copy of positive pregnancy test and anticipated delivery date. *Per ASAM / ACOG guidelines pregnancy is no longer considered an absolute indication for buprenorphine (Subutex®**).**	☐Yes ☐ No Delivery 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? *For pregnant women approval for buprenorphine (Subutex®**)** will expire 90 days postpartum.	☐Yes	☐ No
*Other requests for **Buprenorphine {formerly Subutex®)** 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 TITRATION, please indicated in clinical notes *Cutting films in half where clinically indicated at prescriber discretion is not prohibited by DVHA. However, it is recommended that this should be avoided, particularly if there are children in the home, as the child protection is then lost for the remainder of the dose. In addition, the manufacturer does not recommend splitting the film, and there is a lack of data on uniform potency.		

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature: _____ XDEA License#: _____ Date of request: _____

Last Updated: 12/2022

CHANGE HEALTHCARE

Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~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

Please select all applicable diagnoses for: *Note Suboxone is not FDA approved for alleviation of pain without SUD	☐Acute Pain ☐ Acute on Chronic Pain	☐Chronic Pain ☐ Opioid Use Disorder	
Both ASAM and DVHA Guidelines recommend monitoring for medication diversion and the appropriateness of continued treatment. To ensure patient and public safety, Vermont State Rules governing MAT require diversion monitoring practices. (Section 6.5) Examples used for monitoring include routine toxicology screens, medication counts, and observed dosing.			
Have random toxicological screens (Urine drug screen) been routinely used for this patient? (If yes please submit the results of the 3 most recent.) Have random medication counts been routinely used for this patient? (If yes please submit the results of the 3 most recent.) If the answer to one or both of the above safety questions is NO, or if the patient is new to treatment, please submit results of any other monitoring practices and/or protocol for monitoring new patients. NOTE: The results of monitoring practices will **NOT** be used to make a determination of treatment necessity, but rather as a verification of monitoring protocols.	☐Yes ☐Yes	☐No ☐No	
For patients with dual diagnosis of pain: Please list the diagnosis for pain condition being managed, if applicable: _____ *If the requested medication is **NOT** being used for pain control there will not be a need to fill out any further questions			
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 been consulted and/or have they been referred to a specialist for appropriate management of the pain condition?	☐Yes	☐ No	☐ N/A
Per ASAM Guidelines: "Increasing the daily dose of buprenorphine by 20–25% and splitting it into 3–4 doses can often adequately address acute pain."			
Has split dosing (multiple daily administrations) on current dose been trialed 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	☐Yes	☐ No	☐ N/A
In those treated for **acute pain**, is there a provider plan to taper dose down to minimal effective dosage? (If yes, please submit the taper plan with clinical documentation)	☐Yes	☐ No	☐ N/A

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment

Prescriber Signature:_____ **XDEA License#:**_____ **Date of request:**_____

Last Updated: 12/2022

CHANGE HEALTHCARE