

Prescribing physician:

Physician NPI: Specialty: Phone#: _____

request may subject me to audit and recoupment.

Name:

~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

Medicaid ID#: ______Sex: _____

Pharmacy Name_____

Beneficiary:

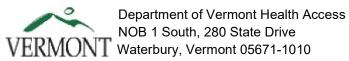
Name:

Fax#:		Pharmacy NPI:Pharmacy Fax:Pharmacy Fax:			=
		Pharmacy Phone:	Pharmacy Fax:	Pharmacy Fax:	
Contact Person	at Office:				
ose:	Dosage Form (e.g. Film):_	Frequency:	(recomm	nended o	nce daily)
	Home" for ALL prescriptions MAY BE sel- e pharmacy you would like member to be				
•	authorization renewal for a member stabl d to safety checklist on page 2. If no, ple	•		□Yes	□ No
For new requent	ests exceeding dosage limits or quantity l n included?	imits has documentation ex	cplaining medical	□Yes	□ No
	is for a nonpreferred oral buprenorphi r the follow question:	ne formulation, including	mono buprenorphine (for	merly Su	butex®),
	al opinion, has the member experienced a resolved or mitigated through alternative		e to the preferred products	□Yes	□No
*If Yes , please	e proceed to safety checklist on page two	1			
	provide clinical documentation explaining e safety checklist on page two	g the need for nonpreferred	formulation in addition to		
*If multiple dos	ses are being requested to facilitate TITR	ATION, please indicated in	ı clinical notes		
that this shou of the dose. Ir	in half where clinically indicated at pres ld be avoided, particularly if there are of a addition, the manufacturer does not re	hildren in the home, as th commend splitting the film	e child protection is then lo , and there is a lack of data	st for the on unifor	remainde n potency

Please document signature on page two

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





Prescriber Signature:_

Last Updated: 06/2023

~BUPRENORPHINE Safety & Compliance Checklist~

The checklist is provided to support prescribers to use 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. DVHA references and aligns with 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:	☐ Acute Pain	☐ Chro	onic Pair	า		
*Note Suboxone is not FDA approved for alleviation of pain without SUD	☐ Acute on Chronic Pain	□Opio	id Use [Disorder		
Both ASAM and DVHA Guidelines recommend monitoring for medication diversalment. To ensure patient and public safety, Vermont State Rules govern (Section 6.5)	ing MAT require diversion moni	toring pra	actices.			
Please select current diversion monitoring practices utilized while treating th practices will subject prior authorization to DVHA clinical staff for further in-d			sion mo	nitoring		
□ VPMS Query □ Patien	nt counselled about diversion ar	nd safe s	torage			
☐ Limited day supply prescriptions (1 week or less) ☐ Rando	andom or follow up medication counts					
□ Random toxicology screens (Urine Drug Screens)						
\square Verification of patient taking medication as directed through monitored $\mathfrak c$	dosing					
$\ \square$ New starts, verification completed to ensure patient is not receiving concurre	ent treatment from alternative pro	vider (Hul	o facility)		
☐ Other methods of diversion monitoring have been completed, Please List:						
NOTE: False or misleading attestation of diversion monitoring practices may disciplinary action, including referral to the medical board or exclusion from		ervices ar	nd/or			
Pain Diagnosis: 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 no	t be a need to till out any further	question	ıs			
Please list the duration of anticipated treatment dose:						
ASAM Guidelines recommend trials of other non-opioid medications and pai buprenorphine dose for pain. Have other medications and modalities been tr 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 bee been referred to a specialist for appropriate management of the pain condition		□Yes	□No	□ N/A		
ASAM Guidelines: Increasing the daily dose of buprenorphine by 20–25% and splitti	ng it into 3–4 doses can often adec	uately ad	dress ac	ute 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 clinical rationale	dose? *If yes, please provide	□Yes	□No	□ N/A		
In those treated for acute pain , is there a provider plan to taper dose down t (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 request is clinically supported in your medical records. I also understand that any misrepresentations or conceal subject me to audit and recoupment						

DEA License#:

Date of request: