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

~SUBLOCADE (Buprenorphine ER) Injection~

Prior Authorization Request Form

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 (SPOKE Providers only)___________________
Pharmacy NPI: ____
Pharmacy Phone: _____________Pharmacy Fax: ___________

The following MUST be completed for HUB requests:

HCPCS J-code or other code: ___________

Administering Provider/Facility: Name______________________ NPI#_________________ Medicaid ID#______________

Dose: ☐ 300mg monthly for the first 2 months followed by a maintenance dose of 100mg monthly

☐ 100mg once monthly

☐ Other: ____ (clinical rationale must be submitted)

Is buprenorphine being prescribed for opioid use disorder? ☐ Yes ☐ No

Current dose of transmucosal buprenorphine: ____________ (patient must be stabilized on a steady dose of 8mg to 24mg for at least 7 days)

****Clinical documentation must be submitted detailing why the member cannot use a more cost effective buprenorphine formulation****

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: 6/2023