VERMONT

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

~ HUB (OTP) BUPRENORPHINE Prior Authorization Form ~

All requests for buprenorphine containing products > 24mg must be reviewed by the Change Healthcare Clinical Call Center. Documentation must accompany this form. For questions, please contact the Change Healthcare help desk at 1-844-679-5363.

Submit request via Fax: 844-679-5366

Prescribing physician:
Name: _____
NPI: _____
Specialty:_____
Phone#:_____
Fax#: _____
Address: _____

Member:
Name: _____
Medicaid ID#:_____
Date of Birth: _____Sex: _____
Diagnosis:_____
Date of Admission to HUB:_____

Contact Person at HUB (OTP):_____

CHECK HERE IF PATIENT IS ADAP UNINSURED ☐

Request is from the following HUB location: _____/ _____
Name **NPI**

☐ **Buprenorphine/Naloxone tablets > 24 mg** Dose per day requested: _____mg

* Clinical note/letter from prescriber that documents the prescriber's clinical rationale for requesting buprenorphine/naloxone tablets >24mg must be attached (REQUIRED). Requests for doses >24mg will require review by DVHA Medical Director.

☐ **Buprenorphine tablets (monotherapy)** Dose per day requested:_____mg

☐ Using buprenorphine monotherapy for up to two weeks to switch from a high potency opioid (methadone/fentanyl) to Suboxone®

☐ Using buprenorphine mono due to a current or past intolerance to preferred/combination products that cannot be resolved or mitigated through alternative efforts

☐ Other_____
* Please provide clinical justification explaining why the member cannot use the preferred buprenorphine formulations

* **> 24 mg** Clinical note/letter from prescriber that documents the prescriber's clinical rationale for requesting buprenorphine tablets (mono formulation) >24mg must be attached (REQUIRED). Requests for doses >24mg will require review by DVHA Medical Director.

☐ **Sublocade® 300 mg (buprenorphine extended-release) injection**
*For patients that remain on 300 mg monthly maintenance dose after two initial doses

*Clinical note/letter from prescriber that documents the member is able to tolerate the 100 mg dose but did not demonstrate a satisfactory clinical response (including supplemental oral buprenorphine dosing, documentation of self-reported illicit opioid use, or urine drug screens positive for illicit opioid use)

Prescriber Signature: _____(stamps not acceptable) Date of request: _____

CHANGE HEALTHCARE