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 Suboxone® Film > 24mg, Buprenorphine/Naloxone tablets, and Buprenorphine monotherapy 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**

□ **Suboxone® Film > 24 mg** Dose per day requested: _____mg
* Clinical note/letter from prescriber that documents the prescriber's clinical rationale for requesting Suboxone® Film >24mg must be attached (REQUIRED). Requests for doses >24mg will require review by DVHA Medical Director.

□ **Buprenorphine/Naloxone tablets** Dose per day requested: _____mg
* FDA Medwatch form documenting a provider observed reaction to Suboxone® Film severe enough to require discontinuation including measures taken to mitigate/manage symptoms must be attached (REQUIRED)

□ **Buprenorphine (mono formulation)** Dose per day requested: _____mg
□ Pregnancy DUE DATE:_____ □ Pregnancy test/ultrasound result/lab attached (REQUIRED)
□ Breastfeeding an opiate dependent baby (baby is being administered morphine or methadone for opiate withdrawal symptoms) *Clinical note/letter from a pediatrician/neonatologist must be attached (REQUIRED)
□ Using buprenorphine mono to switch from methadone to Suboxone® Dates buprenorphine mono will be administered: _____
□ Using buprenorphine mono due to provider observed reaction to both Suboxone® Film and Buprenorphine/Naloxone tablets severe enough to require discontinuation * FDA Medwatch form documenting reaction and measures taken to mitigate/manage symptoms must be attached (REQUIRED)

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

CHANGE HEALTHCARE