FORWARDHEALTH PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR OPIOID DEPENDENCY AGENTS – BUPRENORPHINE

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Opioid Dependency Agents – Buprenorphine Instructions, F-00081A. Providers may refer to the Forms page of the ForwardHealth Portal at <u>www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage</u> for the completion instructions.

Pharmacy providers are required to have a completed PA/PDL for Opioid Dependency Agents – Buprenorphine form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal, by fax, or by mail. Providers may call Provider Services at 800-947-9627 with questions.

SECTION I – MEMBER INFORMATION					
1. Name – Member (Last, First, Middle Initial)					
2. Member ID Number	3. Date of Birth – Member				
SECTION II – PRESCRIPTION INFORMATION					
4. Drug Name	5. Drug Strength				
6. Date Prescription Written	7. Refills				
8. Directions for Use					
9. Name – Prescriber		10. National Provider	Identifier (NP	I) – Prescriber	
11. Address – Prescriber (Street, City, State, Zip+4 Code)					
12. Phone Number – Prescriber					
SECTION III – CLINICAL INFORMATION (Required for all PA requests.)					
13. Diagnosis Code and Description					
14. Is the member 16 years of age or older?		Yes	No		
15. Does the prescriber have a valid Drug Addiction Treatment Act of 2000 (DATA 2000) waiver					
allowing him or her to prescribe buprenorphine-based agents for opioid dependency treatment? U Yes U No					
If yes, enter the prescriber's "X" Drug Enforcement Administration (DEA) number in the space provided.					
16. Is the member taking any other opioids, tramadol, or carisoprodol?		Yes	D No		
If yes, list the drug(s) taken and the dates they have been taken in the space provided.					



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7. Is the member pregnant?	 Y	es 🛛 No
If yes, indicate the member's expected delivery date (mm/dd/ccyy).		
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ECTION IV – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRE EQUESTS (PA requests for a non-preferred buprenorphine-naloxone drug		
 Provide detailed clinical justification for prescribing a non-preferred buprenor Zubsolv, including clinical information why the member cannot use both Subo 		
necessary that the member receive a non-preferred buprenorphine-naloxone		

SECTION V – ADDITIONAL CLINICAL INFORMATION FOR SUBLOCADE REQUESTS (PA requests for Sublocade must be submitted on paper.)

19. Does the member have a moderate to severe opioid use disorder?	C Yes		No		
20. Has the member been initiated on treatment with a transmucosal buprenorphrine-con product delivering the equivalent of 8 mg to 24 mg of buprenorphine daily?	Yes		No		
If yes, provide the member's current transmucosal buprenorphine daily dose and the date therapy was initiated.					
Daily Buprenorphine Dose mg Start Date / Month	// Day	Year			
21. Will Sublocade be used as part of a complete treatment program that includes counse and psychosocial support?	eling	Yes		No	
22. Has the prescriber evaluated the member and determined that a monthly provider-administenance injection of Sublocade is a clinically appropriate treatment regimen?	C Yes		No		
SECTION VI – AUTHORIZED SIGNATURE					
23. SIGNATURE – Prescriber	24. Date Signed	k			
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SECTION VII – FOR PHARMACY PROVIDERS USING STAT-PA						
25. National Drug Code (11 Digits)	26. Days' Su	26. Days' Supply Requested (Up to 183 Days)				
27. NPI						
 Date of Service (mm/dd/ccyy) (For STAT-PA requests, the date of service may be up to 31 days in the future or up to 14 days in the past.) 						
29. Place of Service						
30. Assigned PA Number						
31. Grant Date	32. Expiration Date	33. Number of Days Approved				

SECTION VIII – ADDITIONAL INFORMATION

34. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.