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 www.forwardhealth.wi.gov/WIPortal/Subsystem/Publications/ForwardHealthCommunications.aspx?panel=Forms 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 (NPI) – 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 waiver allowing them to prescribe buprenorphine-based agents for opioid dependency treatment? ❑ Yes ❑ No

If yes, enter the prescriber's "X" Drug Enforcement Administration number in the space provided.

16. Is the member taking any other opioids, tramadol, or carisoprodol? ❑ Yes ❑ No

If yes, list the drug(s) taken and the dates they have been taken in the space provided.

17. Is the member pregnant? ❑ Yes ❑ No

If yes, indicate the member's expected delivery date (mm/dd/ccyy).

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SECTION IV – ADDITIONAL CLINICAL INFORMATION FOR SUBLOCADE REQUESTS

18. Does the member have a moderate to severe opioid use disorder? ❑ Yes ❑ No

19. Has the member been initiated on treatment with a transmucosal buprenorphine-containing product delivering the equivalent of 8 to 24 mg of buprenorphine daily? ❑ Yes ❑ No

If yes, has the member been treated for a minimum of seven days? ❑ Yes ❑ No

20. Will Sublocade be used as part of a complete treatment program that includes counseling and psychosocial support? ❑ Yes ❑ No

21. Has the prescriber evaluated the member and determined that a monthly provider-administered maintenance injection of Sublocade is a clinically appropriate treatment regimen? ❑ Yes ❑ No

SECTION V – ADDITIONAL CLINICAL INFORMATION FOR NON-PREFERRED BUPRENORPHINE-NALOXONE DRUG REQUESTS (PA requests for non-preferred buprenorphine-naloxone drugs must be submitted on paper.)

22. Provide detailed clinical justification for prescribing a non-preferred buprenorphine-naloxone drug instead of both Suboxone film and Zubsolv, including clinical information why the member cannot use both Suboxone film and Zubsolv, and why it is medically necessary that the member receive a non-preferred buprenorphine-naloxone drug instead of Suboxone film and Zubsolv.

SECTION VI – AUTHORIZED SIGNATURE

23. **SIGNATURE** – Prescriber	24. Date Signed

SECTION VII – FOR PHARMACY PROVIDERS USING STAT-PA

25. National Drug Code (11 Digits)	26. Days' Supply Requested (Up to 183 Days)

27. NPI

28. Date of Service (DOS) (mm/dd/ccyy) (For STAT-PA requests, the DOS 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.

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