Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Oral Buprenorphine Containing Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk

Instructions:

Please complete and fax this form back to Kaiser Permanente within 24 hours at **fax: 1-866-331-2104**. If you have any questions or concerns please call 1-866-331-2103. **Request will not be considered unless form is completely filled out.**

The **KPMAS VA Medicaid Formulary can be found at:**

https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_medicaid.pdf

1-Patient Information

Patient Name:_____ Kaiser Medical ID#: _____Date of Birth: _____

Gender: □ Male □ Female Phone #: _____

Is the patient Pregnant?" □ Yes □ No If yes, Document Expected Date of Delivery _____

Positive pregnancy test must be provided as part of this request. Is it attached? □ Yes □ No

Buprenorphine monotherapy will only be covered during the following:

- pregnant women for a maximum of 10 months,
- when converting a patient from methadone or buprenorphine mono-product to buprenorphine/naloxone for a period not to exceed 7 days
- when formulations other than tablet form for indications approved by FDA are used
- No other indications will be accepted.

2-Provider Information

Provider Name:_____ Provider NPI: _____ Specialty:_____

DEA x #: _____DEA X # Exp: _____

Provider Address:_____ Provider Phone #: _____Provider Fax #:_____

Please check the box that applies: □ Standard Review (72 hours) □ Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Providers Signature_____ Date: _____

3- Oral Buprenorphine Products Quantity Limits

Preferred Products Maximum Quantities					
buprenorphine/naloxone SL tab 2–0.5mg 8/day			**buprenorphine/naloxone SL tab 8–2mg 2/day**		
Non-Preferred Maximum Quantities					
buprenorphine SL tab 2mg	8/day	Suboxone® SL film 12–3mg	1/day	Zubsolv™ SL tab 2.9–0.71mg	4/day
buprenorphine SL tab 8mg	2/day	Bunavail™ 2.1–0.3mg buccal film	4/day	Zubsolv™ SL tab 5.7–1.4mg	2/day
Suboxone® SL film 2–0.5mg	8/day	Bunavail™ 4.2–0.7mg buccal film	2/day	Zubsolv™ SL tab 8.6–2.1mg	1/day
Suboxone® SL film 4–1mg	4/day	Bunavail™ 6.3–1mg buccal film	1/day	Zubsolv™ SL tab 11.4–2.9mg	1/day
Suboxone® SL film 8–2mg	2/day	Zubsolv™ SL tab 1.4–0.36mg	8/day	Zubsolv ™ SL tab 0.7-0.18 mg	16/day

4-Therapy Information

Drug Name/Form: _____Strength_____ Total Daily Dose: _____

1. Is the request for a non-preferred product? □ Yes □ No

If yes, please provide medical necessity information and reason why a non-preferred product is required. Include details for adverse reactions to combination products:_____

2. Is the request for a dose >16 mg/day? □ Yes □ No

If yes, please provide clinical rationale including documentation of why this higher dose is medically necessary:

_____

****Doses Greater than 24 mg per day WILL NOT be approved

5-Medical Information

3. Does patient meet criteria for a diagnosis of Opioid Use Disorder? □ Yes □ No
(defined by DSM 5: http://pcssmat.org/wp-content/ uploads/ 2014/02/5 B-DSM-5-Opioid-Use-Disorder-Diagnostic- Criteria.pdf)

4. Is the patient 16 years of age or older? □ Yes □ No

5. Is this patient in induction phase or maintenance phase? □ Induction □ Maintenance

6. **Induction Phase-Psychological Counseling**

   a. For **Initial Treatment** (1st 3 months), is the patient participating in psychosocial counseling (individual or group) at least once per week? □ Yes □ No

7. **Maintenance Phase- Psychological Counseling**

   a. For **Maintenance** (after the 1st 3 months), Is the patient participating in psychosocial counseling (individual or group) at lease once to twice per month? □ Yes □ No

Provide name and phone number of behavioral health care provider that is providing counseling info

Provider Name: _____Phone #: _____ Fax #: _____

6-Concurrent Medication Use

8. Has the prescriber reviewed the Virginia Prescription Monitoring Program (P) **before the Initiation of therapy and during maintenance?** https://www.pmp.dhp.virginia.gov/VAPMPWebCenter/login.aspx

Document fill **date of last opioid RX** _____ Document fill **date of last benzodiazepine Rx** _____

9. Is the patient taking any of these medications: benzodiazepine, opioids, sedative hypnotics, tramadol, carisoprodol? □ Yes □ No

If yes, provide extenuating circumstances of co-prescribing of one of these medications and include a tapering plan_____

_____

Has the tapering plan been provided? □ Yes □ No

7-Urine Drug Screening During Maintenance Phase

10. Is the prescriber checking random urine drug screens at least **4 times per 6 months?** □ Yes □ No

- The urine drug screens **MUST** check for buprenorphine, norbuprenorphine, methadone, oxycodone, benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates

11. The prescriber must provide **the last 2 urine drug screens (with at least 1 of these screenings within the past month**. Is this attached? □ Yes □ No

12. Are all urine drug screens positive for buprenorphine/norbuprenorphine? □ Yes □ No

13. Are all urine drug screens negative for all other substances? □ Yes □ No

- If a drug screen is negative for buprenorphine/norbuprenorphine and/or positive for another substance, provide written documentation of steps being taken to address patient's possible diversion of buprenorphine and/or ongoing use of other substances including intensifying the counseling that patient is receiving and/or considering referral to higher level of care (such as intensive outpatient, partial hospitalization, or residential treatment). Is the written documentation attached? □ Yes □ No

8- Provider Sign off

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**