



September 5, 2013

Montana Health Care Programs Notice

Pharmacy, Physician, and Mid-Level Practitioner

Updated Prior Authorization Request Form for Suboxone® and Subutex®

To request an initial prior authorization, submit the information required on the Montana Medicaid Suboxone® or Subutex® Prior Authorization Request Form as updated to the Drug Prior Authorization Unit. Submission of the Prior Authorization Request Update will be required at intervals of 2, 4, 6, 12, 18, and 24 months for continuation of therapy beyond the initial prior authorization.

Requirements for Suboxone® are below. **Maximum dose limitations for Suboxone® apply.**

- Patient must be 16 years or older.
- Initial approval will be granted for 2 months. Dosing will be limited to maximum buprenorphine 24 mg/day. Requests for >24 mg/day will require provider documentation.
- Documentation of compliance with counseling, drug screens (including buprenorphine and drugs of abuse), and office visits must be provided for continuation of therapy beyond the initial 2 months of therapy.
- Review and approval will be required at 4 months to verify continued patient compliance.
- After 6 months, approval may be granted for additional 6 month intervals up to 18 months to allow for a total of 24 months of therapy. Dosing will be limited to maximum buprenorphine 16 mg/day.
- Requests for dose increases will require provider documentation.
- Concurrent opioids, tramadol, or carisoprodol will not be covered. If a patient has prior authorization for Suboxone®/Subutex® after meeting all criteria and subsequently discontinues the medication, all opioids, tramadol formulations, and carisoprodol will remain on not-covered status.

These medications require prior authorization for any future prescriptions. Approval may be granted short-term for an acute injury, hospitalization, or other appropriate diagnosis only after the case is reviewed with the treating physician and the physician prescribing Suboxone®/Subutex®.

Prior authorization for Subutex® is limited to 5 days to allow induction in the absence of a pregnancy diagnosis. For pregnancy, Subutex® will be authorized only for the duration of the pregnancy or nursing. Documentation of a positive pregnancy test is required at initiation and at 4 months of therapy.

Approval may be canceled at any time if patient fails to comply with treatment plan:

- Failure to establish with and attend counseling sessions; or
- Missed or inappropriate results from drug screens; or
- Breaking the controlled substance/treatment contract.

Documented compliance with counseling, drug screens, and office visits is required for continuation of therapy. Review and approval will also be required at intervals of 2, 4, 6, 12, 18, and 24 months to verify patient compliance.

Contact Information

If you have any questions regarding this notice, contact the Medicaid Drug Prior Authorization Unit at 406.443.6002 or contact Dave Campana at 406.444.5951 or dcampana@mt.gov.

For claims questions or additional information, contact Provider Relations at 1.800.624.3958 (toll-free, in/out of state) or 406.442.1837 (Helena) or via e-mail at MTPRHelpdesk@xerox.com.

Visit the Provider Information website at <http://medicaidprovider.hhs.mt.gov>.



3404 Cooney Drive, Helena, MT 59602
 Phone (406) 443-6002 - Toll Free Phone 1-800-395-7961
 Fax (406) 513-1928 - Toll Free Fax 1-800-294-1350

"The best quality health care is provided to every patient we serve, every time."

Montana Medicaid
Suboxone® (buprenorphine/naloxone) or Subutex® (buprenorphine)
Prior Authorization Request Update

- ___ 2 month update ___ 4 month update
 ___ 6 month update (NOTE: MAX benefit after 6 months is 16 mg/day)
 ___ 12 month update
 ___ 18 month update
 ___ 24 month update – Benefit maximum has been reached. Please provide wean off plan.

Patient's Name _____ Date _____

Patient I.D. Number _____ D.O.B _____

Physician's Name: _____

Physician's Phone #: _____ Physician's Number: _____

➤ **Please answer the following questions:**

1. Documentation of participation in CD counseling is attached	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has patient been compliant with all scheduled office visits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has patient been compliant with <u>and</u> had appropriate random urine drug screening results (including buprenorphine and drugs of abuse)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Will patient dose be adjusted to max 16 mg/day? If not, provider to provide documentation for coverage consideration.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
5. If Subutex® is requested (one of the following must be met):	
A. Patient is pregnant (current positive PG test attached if 4 months)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
B. Patient is currently nursing.	NA
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
	NA

Additional Information _____

Please complete form and fax to:
 Medicaid Drug Prior Authorization Unit
 1-800-294-1350

Important Notice

The attached information is CONFIDENTIAL and is intended only for the use of the addressee(s) identified above. If the reader of this message is not the intended recipient(s) or the employee or agency responsible for delivering the message to the intended recipient(s), please note that any dissemination, distribution or copying of the communication is strictly prohibited. Anyone who receives this in error should notify us immediately by telephone, toll-free at (800) 395-7961 or locally at 406-443-6002 and return the original message to us at the address above via U. S. Mail.

Montana Medicaid Suboxone®/Subutex® Authorization Limitations

Covered Condition – Treatment of Opioid Addiction

Subutex®: Approvals will be limited to 5 days to allow for induction in the absence of a pregnancy diagnosis.

For pregnancy, Subutex® will be authorized only for the duration of pregnancy or nursing. Documentation of a positive pregnancy test is required at initiation and at 4 months of therapy.

Maximum dose limitations for Suboxone® will apply.

Suboxone®:

- Patient must be 16 years or older.
- **Initial approval will be granted for 2 months. Dosing will be limited to maximum buprenorphine 24 mg/day. Requests for >24 mg/day will require provider documentation.**
 1. **Documentation of compliance with counseling, drug screens (including buprenorphine and drugs of abuse), and office visits must be provided for continuation of therapy beyond the initial 2 months of therapy.**
 2. **Review and approval will be required at 4 months to verify continued patient compliance.**
- After 6 months, approval may be granted for additional 6 month intervals up to 18 months to allow for a total of 24 months of therapy. Dosing will be limited to maximum buprenorphine 16 mg/day.
- Requests for dose increases will require provider documentation.
- Concurrent opioids, tramadol, or carisoprodol will not be covered. If a patient is Prior Authorized for Suboxone®/Subutex® after meeting all criteria and subsequently discontinues the medication, all opioids, tramadol formulations, and carisoprodol will remain on not-covered status. These medications will require Prior Authorization for any future prescriptions. Approval may be granted short-term for an acute injury, hospitalization, or other appropriate diagnosis only after the case is reviewed with the treating physician and the physician prescribing Suboxone®/Subutex®.

Note: Approval may be cancelled at any time if patient fails to comply with Treatment Plan: failure to establish with and attend counseling sessions; missed or inappropriate results from drug screens; breaking controlled substance/treatment contract.