

January 27, 2014

# Montana Health Care Programs Notice

## Physician, Mid-Level, and Pharmacy Providers

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**Effective February 27, 2014**

### Prior Authorization for Zubsolv<sup>®</sup>

Zubsolv<sup>®</sup> (Buprenorphine/naloxone) is now a covered product for Montana Medicaid. Requirements for Zubsolv<sup>®</sup> and Suboxone<sup>®</sup> film are as follows. The Prior Authorization Request Form, Physician Chart Check List, and Prior Authorization Update Form have been updated to include Zubsolv<sup>®</sup> and are posted to the Pharmacy provider page.

- Patient must be 16 years or older;
- Initial approval will be granted for **2 months**. Dosing will be limited to a maximum of:
  - 24 mg/day for Suboxone<sup>®</sup> film
  - 17.1 mg/day for Zubsolv<sup>®</sup>*\*Requests for doses exceeding the maximum 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.
- Review and approval will be required at 4 months of therapy to verify continued patient compliance.
- After 6 months, approval may be granted for additional 6 month intervals up to 18 months, for a total of 24 months of therapy.
- Dosing will be limited to a maximum of:
  - 16 mg/day for Suboxone<sup>®</sup> film
  - 11.4 mg/day for Zubsolv<sup>®</sup>*\*Requests for dose increases will require provider documentation.*
- Concurrent use of opioids, tramadol, or carisporodol will not be covered. If a patient is prior authorized for Suboxone<sup>®</sup>/Subutex<sup>®</sup>/Zubsolv<sup>®</sup> after meeting all criteria and **subsequently discontinues the medication, all opioids, tramadol formulations, and carisporodol will remain on a 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<sup>®</sup>, Subutex<sup>®</sup>, or Zubsolv<sup>®</sup>.

### Contact Information

Drug Prior Authorization Unit  
Mountain-Pacific Quality Health  
3404 Cooney Drive  
Helena, MT 59602  
406.443.6002 or 1.800.395.7961 (Phone)  
406.513.1928 or 1.800.294.1350 (Fax)

Questions regarding this notice can be directed to Dave Campana, R.Ph., at 406.444.5951 or [dcampana@mt.gov](mailto:dcampana@mt.gov), or Katie Hawkins at 406.444.2738 or [khawkins@mt.gov](mailto:khawkins@mt.gov), or the Medicaid Drug Prior Authorization Unit at 406.443.6002.

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](mailto: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 Prior Authorization Request Form for Use of Suboxone®, Zubzolv® (buprenorphine/naloxone) or Subutex® (buprenorphine)**

**Coverage Restricted Exclusively for the Treatment of Opioid Addiction**

Providers must submit their **Treatment Plan** before authorization will be considered.

At a minimum the **Treatment Plan** must include the following information:

- Documentation of assessment and screening for opioid dependence (DAST-10, DSM-IV)
- Documentation of opioid substance of abuse
- Documentation of proposed counseling schedule
- Documentation of proposed monitoring plan (urine drug screens, random pill counts, etc.)
- Copy of Controlled Substance/Treatment Contract which must include consequences for failure to comply

**(Please note authorization limitations on page 2)**

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient I.D. Number:** \_\_\_\_\_ **D.O.B:** \_\_\_\_\_

**Physician's Name :** \_\_\_\_\_

**Physician's Phone #** \_\_\_\_\_ **Physician's Fax Number:** \_\_\_\_\_

**Drug/Dose Request:** \_\_\_\_\_ (mg) **Daily Directions:** \_\_\_\_\_ (i.e.: 1 QD)

**Is patient pregnant or nursing?** \_\_\_\_\_ **If Yes, Due Date?** \_\_\_\_\_  
(Note: If pregnant, documentation of a positive pregnancy test required to utilize Subutex®)

**Signature of Physician:**  
\_\_\_\_\_

**DEA#: X-** \_\_\_\_\_ **(Prescriber must have an X-DEA Number)**

**Please complete form, attach documentation 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/Zubzolv® 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 4 months of therapy.

Maximum dose limitations for Suboxone® will apply.

### **Suboxone®/Zubzolv®:**

- 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 for Suboxone® film and 17.1 mg/day for Zubzolv®. Requests for doses exceeding this 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 of therapy 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 Suboxone® film 16 mg/day and 11.4 mg/day for Zubzolv®.
- 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®/Zubzolv® 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®/Zubzolv®.

**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.**



**Montana Medicaid  
Suboxone®/Subutex®/Zubsolv®-PA Requirements  
Physician Chart Check List**

Patient Name: \_\_\_\_\_  
Patient ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Copy of Assessment and Screening for Opioid Dependence (DAST-10, DSM-IV) or other supporting documentation

Opioid Substance(s) of Abuse \_\_\_\_\_

Psychosocial counseling referral made to \_\_\_\_\_  
\_\_\_\_\_

Proposed counseling schedule\* (weekly, q o week, etc.) \_\_\_\_\_  
\_\_\_\_\_

***\*Patient informed that counseling is required. Documentation of active involvement in counseling must be submitted for continuation after initial month of therapy.***

Monitoring Plan (urine drug screens including buprenorphine and drugs of abuse, random pill counts, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

Copy of treatment contract signed by patient

If female, is patient pregnant? Yes  No

If yes, documentation of a positive pregnancy test is attached if Subutex® requested Yes  No

Will patients OB care provider be contacted? Yes  No

**\*\*Recommend interface with provider to establish post-delivery plan for newborn (treatment of neonatal withdrawal syndrome). There are no adequate or well-controlled studies of Suboxone®/Subutex® in pregnancy (Cat C)**

**OB Provider:** \_\_\_\_\_ **Date Contacted:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

This checklist is designed to aid the provider in completing the requirements necessary to obtain Prior Authorization for the use of Suboxone®/Subutex®/Zubsolv® through Montana Medicaid.

All requirements herein may be faxed to the Montana Medicaid Drug Prior Authorization Unit at 1-800-294-1350 along with the Prior Authorization for Suboxone®/Subutex® Request Form.