



**Montana Medicaid
Buprenorphine-containing products for Opioid Substance Use Disorder
Prior Authorization Request Form**

(Please note authorization limitations on page 2)

| | | |
|------------------------|--|--------------|
| Patient Name: | Patient Medicaid ID#: | Patient DOB: |
| Physician Name: | Physician DEA#(X-DEA required): X- | |
| Physician Phone #: | Physician Fax #: | |
| Drug/Dose Request (mg) | Daily Directions (i.e. 1 QD) | |

Provider attests patient Treatment Plan includes all of the following information (please check):

- Patient assessment/screening supports a diagnosis of **moderate to severe Opioid SUD** (DSM-V Criteria)
- Patient will be referred for counseling assessment and counseling.
 - Patient **has been informed** counseling is required.
- Proposed monitoring plan includes both:
 - Random urine drug screens (including drugs of abuse and buprenorphine)
 - Random pill counts
- Treatment Contract has been signed by patient
- Pregnant or nursing patient-the following section must be completed:

- If pregnant, EDD: _____
- If buprenorphine *monotherapy* is requested, **documentation of positive pregnancy test is attached.**
- Treatment provider attests that OB provider has been contacted to establish post-delivery plan for newborn (treatment of neonatal withdrawal syndrome).
 - OB Provider Name: _____ Date Contacted: _____
 - OB Phone #: _____

Signature of Physician: _____ Date: _____

**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
Buprenorphine-containing products
Authorization Limitations

Coverage Restricted Exclusively for the Treatment of moderate-severe Opioid Substance Use Disorder (SUD)

Buprenorphine monotherapy:

- Approvals will be limited to 5 days to allow for induction in the absence of a pregnancy diagnosis.
- For pregnancy, buprenorphine monotherapy will be authorized only for the duration of pregnancy or nursing. Documentation of a positive pregnancy test is required at initiation.
- Maximum dose limitations will apply as below.

Buprenorphine/naloxone products:

- Patient must be 16 years or older.
- Initial authorization is limited to 6 months. Maximum dose 24 mg/day.
- At 6 months, provider will need to submit an update form indicating compliance with counseling, drug screens (including buprenorphine and drugs of abuse), and office visits.
 - Maximum dose authorized to be 16 mg/day.
 - Reauthorization will be issued at 6 month intervals pending additional updates.
- At 24 months, provider will need to submit an updated treatment plan.
- Requests for dose increases above maximum quantity limits will require clinical rationale documentation.
- Concurrent opioids, tramadol, or carisoprodol will not be covered.
 - If a patient is Prior Authorized for treatment 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 the buprenorphine containing product.

Important Notes:

1. Please consult the current Montana Medicaid Preferred Drug List for preferred agents (<http://medicaidprovider.mt.gov/Portals/68/docs/current/mtpdlcurrent.pdf>) .
2. Approval may be cancelled by MT Medicaid at any time if patient fails to comply with Treatment Plan: i.e. failure to establish with, and attend counseling sessions; missed or inappropriate results from drug screens; breaking controlled substance/treatment contract; scheduled office visits; provider dismissal.
3. Change in provider will require complete initial request documentation. Approval or denial will be dependent on rationale for the provider change.

Montana Medicaid
Buprenorphine-containing products for Opioid Substance Use Disorder
Prior Authorization Request Update

| | | |
|--------------------|--|--------------|
| Patient Name: | Patient Medicaid ID#: | Patient DOB: |
| Physician Name: | Physician Fax #: | |
| Physician Phone #: | Drug/Dose Request (mg) & Daily Directions (i.e. 1 QD): | |

| Please complete the following information*: | Yes | No | N/A |
|--|------------|-----------|------------|
| 1. Patient has been actively participating in CD counseling per plan? | | | |
| 2. Patient has been compliant with all scheduled office visits? | | | |
| 3. Patient has been dose-adjusted to \leq 16 mg/day? | | | |
| If buprenorphine <i>monotherapy</i> is requested, <u>one</u> of the following must be met: | | | |
| A. Patient is pregnant | | | |
| B. Patient is nursing | | | |

***Provide additional supporting clinical information/plan if answered no to any of above:**

Provider attests patient is compliant with treatment plan and is making clinically meaningful progress towards treatment goals.

Provider signature: _____ **Date:** _____

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