Sublocade™
January 16, 2019

Prior Authorization Criteria for

Sublocade™ (buprenorphine extended-release)

Version 1 Published 01-16-2019

PLEASE READ to prevent your claim from being **DENIED**

Sublocade™ is always administered in a physician office. However, it can be purchased and billed two different ways. It is imperative that you correctly indicate how you will be billing the medication to ensure payment.

Pharmacy Point-of-Sale

A prescription for a **specific patient** can be sent to a pharmacy that is enrolled with the Sublocade™ REMS program. This is billed by the enrolled pharmacy to the Montana Healthcare Pharmacy Program. The medication is then sent to the provider to administer to that specific patient. The provider will only bill Montana Healthcare Programs for the administration fee, not the medication. In this situation, please fill out the prior authorization form and select "pharmacy point of sale" when asked to indicate which benefit you would like the prior authorization entered under.

Medical/Physician Services

Sublocade™ can also be ordered by a healthcare setting (ie. a clinic or provider) who is enrolled with the Sublocade™ REMS program as a **dispenser**. The medication is not ordered for a specific patient. When the provider administers this medication, the healthcare facility will bill the physician's program for both the medication and the administration fee. In this situation, please fill out the Physician Administered Drugs Prior Authorization form (found on the forms page of the medicaidprovider.mt.gov webpage) and the prior authorization form, selecting "medical" when asked to indicate which benefit you would like the prior authorization entered under.

If you are not sure how your facility will be billing, please call Cassie O'Bryant (Physician Program Officer) at 406-444-3995 or Dani Feist (Pharmacy Program Officer) at 406-444-2738 for further assistance.

Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health

3404 Cooney Drive, Helena, MT 59602
Phone 406.443.6002 • Toll-Free 1.800.395.7961
Fax 406.513.1928 • Toll Free 1.800.295.1350

Montana Medicaid
Prior Authorization Request form for use of Sublocade (buprenorphine extended-release)

Patient Name:		Patient Medicaid ID#:	Patient DOB:
Provider Name:		Provider **X-DEA:**	
Provider Phone #:	Provider fax #:	Dose/regimen requested:	
Indicate the benefit you would like the PA entered under: ☐ Medical (Physician Services) ☐ Pharmacy Point of Sale			

1. **Patient is 18 years of age or older.** ☐ Yes ☐ No
2. **Patient has been stabilized on a buprenorphine transmucosal dose delivering an equivalent of 8-24 mg for a minimum of *7* days.** ☐ Yes ☐ No
3. **Concurrent use of strong CYP inhibitors or inducers is not recommended. Provider has evaluated potential drug interactions** ☐ Yes ☐ No
4. **Provide clinical rationale documenting necessity to switch to injectable product:**

_____

_____

5. **Provider attests patient Treatment Plan** includes ***all*** of the following (please check) and ***will be documented*** in patient chart (case notes do not need to be sent unless specifically requested):
   - ☐ Patient assessment/screening supports a diagnosis of ***moderate to severe*** **Opioid SUD** (DSM-V Criteria).
   - ☐ Patient will be referred for counseling assessment and counseling.
   - ☐ Proposed monitoring plan includes random urine drug screens (to include drugs of abuse *and* buprenorphine).
   - ☐ Treatment Contract has been signed by patient ***and patient understands section "B" below.***
   - ☐ Pregnant patient - Please complete the following information:

     If pregnant, EDD: _____ Risk/benefit has been discussed with patient: ☐ Yes ☐ No
     Treatment provider attests that OB provider has been contacted to establish post-delivery plan (for treatment of neonatal withdrawal syndrome):
     OB Provider Name: Phone: Date contacted:

   A. Limitations:
   - **Maximum dose authorized will be 300 mg monthly x 2 months, followed by 100 mg x 4 months.**
   - **Initial authorization will be for 6 months. For renewal, provider must attest patient is making clinically meaningful progress towards treatment goals. Subsequent renewals x 1 year.**

   B. Concurrent opioids, tramadol, or carisoprodol will *not* be covered with buprenorphine-containing products.
   - **If a patient subsequently discontinues the buprenorphine-containing product, 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 provider and the provider prescribing the buprenorphine-containing product.

6. **Consideration will be made to offer patient a naloxone rescue prescription & education:** ☐ **Yes** ☐ **No**
   (Products *available without PA* are Narcan® nasal spray, naloxone vial for injection, naloxone prefilled syringe for injection)

Signature of Provider: _____ Date: _____

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

Mail or Fax completed form to: DPHHS
PO Box 202951
Helena, MT 59602
Fax: 406-444-1861
Physician Program: 406-444-3995
Hospital: 406-444-7018

Montana Healthcare Programs

Request for Physician Administered Drug Prior Authorization

Please Type or print:

Today's Date: _____ Contact Person: _____ Phone Number: _____

Patient's Name (Last, First, MI: _____ Medicaid #: _____ Date of Birth: _____
Therapy will be provided in:
Provider Office: _____ Outpatient Hospital (Infusion Ctr, CAH, etc.): _____ ASC: _____

Rendering Provider Name: _____ NPI (not TIN): _____ Fax Number: _____
If applicable, Outpatient
Hospital or ASC Facility Name: _____ NPI (not TIN): _____ Fax Number: _____
HCPCS Code: _____ Diagnosis-ICD 10: _____ Description: _____
NDC: _____ Units per Treatment: _____
Is this an extension of an existing prior authorization?
Yes_____ No _____
Date Therapy Will Be Initiated: _____
Pertinent Information: _____
_____
Dosage & Therapy Plan: _____
_____
Medical Records Attached Yes_____ No _____

Prior Authorization Unit Only

Important Note: In evaluating requests for prior authorization, the consultant will consider the therapy from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider of service to bill correctly and to verify Medicaid eligibility. Current member eligibility may be verified by calling Conduent State Healthcare, LLC at 1-800-9624-3958 or 406-442-1837.

Date: _____ Approval/Denial Status: _____ Date Spans Approved: _____

Reason for denial of therapy prior authorization: _____

HCPS Code: _____ Prior Authorization Number: _____

Mountain-Pacific Quality Health

Academic Detailing Initiative

Co-Prescribing Naloxone with Opioids in High Risk Patients

Practical ✒ **Unbiased** ✒ **Evidence-Based**

Naloxone is a prescription opioid antagonist indicated for the emergency treatment of severe respiratory depression associated with known or suspected opioid overdose. The 2016 U.S. Centers for Disease Control and Prevention (CDC) "Guideline for Prescribing Opioids for Chronic Pain" recommends evaluating patients for risk factors for opioid-related harms before starting opioid therapy, and during therapy continuation. *It is recommended **not** to initiate opioids when factors that increase opioid-related harms are present. However, if the decision is made to prescribe an opiate in the presence of certain risk factors, the CDC recommends considering offering naloxone as part of an overall strategy to help mitigate patient risk. Re-evaluating patients more frequently and referral to pain and/or behavioral health specialists is also recommended.*

Consider offering naloxone with opioid therapy if *any* of the following risk factors which can increase risk of opioid overdose are present:

- *A history of prior overdose*
- *A history of substance use disorder*
- *Concurrent benzodiazepines and opioid use*
- *In patients at risk for returning to a high dose to which they are no longer tolerant*
- *In patients taking higher dosages of opioids (≥50 MME/day) which is:*
  - *≥50 mg of hydrocodone per day*
  - *≥33 mg of oxycodone per day*
  - *≥12 mg of methadone per day*

From 1999 to 2014, more than 165,000 persons died from overdose related to opioid pain medication in the United States

The following naloxone products *do not require prior authorization* by Montana Medicaid when a prescription is provided to your patient:

- Naloxone prefilled syringe for injection
- Naloxone vial for injection
- Narcan® nasal spray

The complete CDC guideline can be accessed at https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.
Resources for prescribing naloxone in primary care can be found through http://prescribetoprevent.org/.

6/2017