

December 15, 2009

# Montana Healthcare Programs Notice

## Pharmacies, Physicians, Mid-Level Practitioners

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### Updated Prior Authorization Request Form, Prior Authorization Request Update and Physician Chart Checklist for Suboxone<sup>®</sup> or Subutex<sup>®</sup>

Effective immediately, prior authorization for Suboxone<sup>®</sup> or Subutex<sup>®</sup> will be limited to an initial one-month period. Documented compliance with counseling, drug screens and office visits will be required for continuation of therapy. Review and approval will also be required at two-, four- and six-month intervals to verify patient compliance.

To request initial prior authorization, prescribers with an X-DEA Number must submit the information required on the attached *Montana Medicaid Prior Authorization Request Form for Use of Suboxone<sup>®</sup> or Subutex<sup>®</sup>* to the Drug Prior Authorization Unit.

Submission of the attached *Prior Authorization Request Update* will be required at one-, two-, four- and six-month intervals for continuation of therapy beyond the initial month.

Also attached is the *Physician Chart Check List* designed to aid the provider in completing the requirements necessary to obtain prior authorization.

Any questions regarding this notice can be directed to Wendy Blackwood at (406) 444-2738 or the Medicaid Drug Prior Authorization Unit at (406) 443-6002.

### Contact Information

For claims questions or additional information, contact Provider Relations:

**Provider Relations toll-free in- and out-of-state: 1-800-624-3958**

**Helena: (406) 442-1837**

**E-mail: [MTPRHelpdesk@ACS-inc.com](mailto:MTPRHelpdesk@ACS-inc.com)**

Visit the Provider Information website:

**<http://www.mtmedicaid.org>**



3404 Cooney Drive, Helena, MT 59602  
Phone (406) 443-6002 - Toll Free Phone 1-800-395-7961  
Fax (406) 443-7014 - 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® (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? \_\_\_\_\_

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® 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. Maximum dose limitations for Suboxone® will apply.

**Suboxone®:**

- Patient must be 16 years or older.
- **Initial approval will be granted for 1 month. 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 screen, and office visits must be provided for continuation of therapy beyond the initial month of therapy.**
  2. **Review and approval will be required at 2 and 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.**



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

- 1 month 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 Fax Number: \_\_\_\_\_

➤ **Please answer the following questions:**

|   |                              |  |
|---|------------------------------|--|
| <b>1. Documentation of participation in CD counseling is attached.</b>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                              |
| <b>2. Has patient been compliant with all scheduled office visits?</b>  | <input type="checkbox"/> Yes | <input type="checkbox"/> No                              |
| <b>3. Has patient been compliant with <u>and</u> had appropriate random urine drug screening results?</b>                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No                              |
| <b>4. Will patient dose be adjusted to max 16 mg/day?<br/>IF not, provider to provide documentation for coverage consideration.</b> | <input type="checkbox"/> Yes | <input type="checkbox"/> No <input type="checkbox"/> N/A |

Additional Information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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**Montana Medicaid  
Suboxone®/Subutex®-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, random pill counts, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Copy of treatment contract signed by patient

|   |
|---|
| <p>If female, is patient pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Will patients OB care provider be contacted? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>**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)</b></p> <p>OB Provider: _____ Date Contacted: _____</p> <p>Phone: _____</p> |
|---|

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