Montana Healthcare Programs
Buprenorphine-Containing Products (Transmucosal) for Opioid Use Disorder
Prior Authorization Request Form

Please read and complete.

Patient Name **Patient Medicaid ID** **Patient DOB**

Provider Name **Provider DEA# (X-DEA required)**

Provider Telephone **Provider Fax**

Drug/Dose Request (mg) **Daily Directions (e.g., 1 QD)**

Please read and complete. Use check box to verify the information has been provided.

1. ☐ Provider is a Montana Healthcare Programs enrolled provider and as such, adheres to the requirements in the Addictive and Mental Disorders Division (AMDD) MAT Policy. The complete policy is found at the link AMDD Medicaid Services Provider Manual (mt.gov).
2. Provider attests patient Treatment Plan includes ***all*** of the following and ***is documented*** in the patient chart.
   - ☐ Patient is 16 years of age or older.
   - ☐ Patient assessment/screening supports a diagnosis of **moderate to severe** Opioid SUD (DSM-V Criteria).
   - ☐ Behavioral health assessment and engagement in counseling will be recommended. If recommendation accepted, referral assistance will be provided if resources are available. If patient is not ready for change, periodic re-assessment of readiness will occur. Lack of counseling is not a reason to withhold treatment.
   - ☐ Proposed monitoring plan includes random pill counts and random urine drug screens (to include drugs of abuse **and** buprenorphine).
   - ☐ Treatment contract, including patient's acknowledgement of his/her understanding of section B below, has been signed by patient. **The Department may request a copy of the signed treatment contract at any time.**
   - ☐ For pregnant patients only, complete the following information:

     Estimated Date of Delivery (EDD)

     Treatment provider attests that OB provider has been contacted to establish post-delivery plan (for treatment of neonatal withdrawal syndrome):

     OB Provider Name

     Telephone **Date Contacted**

Limitations (specific product subject to Preferred Drug List requirements):

A. Quantity Limits (ongoing reassessment to establish the lowest effective dose is recommended):
- SUBOXONE film 8 mg/2 mg **or** 2 mg/0.5 mg: Max 3 films daily. Authorized for 1 year with annual update required.
- Buprenorphine SL 2 mg **or** 8 mg: Max 3 tablets daily. Authorized only for max 5 days for induction **or** duration of pregnancy **or** written documentation is provided of ADR to a prescribed combination product.

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.

3. **Consideration will be made to offer patient a naloxone rescue prescription and education.**
   ◯ **Yes** ◯ **No**

(Products available without PA are Narcan® nasal spray, naloxone vial for injection, naloxone prefilled syringe for injection.)

Provider Signature **Date**

Please fax completed form to the Montana Healthcare Programs Drug Prior Authorization Unit at (800) 294-1350.