Montana Healthcare Programs
SUBLOCADE® (Buprenorphine Extended-Release)
Prior Authorization Request Form

Please read and complete.

Patient Name	Patient Medicaid ID	Patient Date of Birth
Provider Name	Provider X-DEA	
Provider Telephone	Provider Fax	
Dose/Regiment Requested	Benefit the PA is entered under (e.g., Medical/Physician Service, Outpatient Pharmacy)	

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

6. Provider attests patient Treatment Plan includes ***all*** of the following and ***is documented*** in the patient chart. **Chart 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).
   - ☐ Behavioral health assessment and engagement in counseling will be recommended. If recommendation is 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 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**)

     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

     Telephone **Date Contacted**

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A. Limitations

- Maximum dose authorized will be 300 mg monthly x two (2) months, followed by 100 mg x four (4) months.
- Initial authorization will be for six (6) months. For renewal, provider must attest patient is making clinically meaningful progress towards treatment goals. Subsequent renewals x one (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.

7. 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.