Montana Healthcare Programs
Provider Attestation for SUBOXONE® for Opioid Use Disorder

Please attest that all of the following intake and treatment plan measures are routinely followed for Montana Healthcare Program members.

Providers who submit this form will no longer have to fill out individual prior authorization request forms for Suboxone films. An electronic prior authorization (PA) will be automatically assigned at the pharmacy. Note: This is for Suboxone films only. Other buprenorphine products require a manual PA.

Providers employed by an all-inclusive opioid treatment program (OTP) facility, where medications are billed through the medical benefit, will be excluded from this PA exemption process.

This will go into effect July 15, 2019, or 2 weeks after signed form is received by the Department, whichever is later. Please continue with the current process until that time.

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

Provider NPI **Provider Telephone**

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 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 substance use disorder (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 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.**

Limitations (specific product subject to Preferred Drug List requirements)

A. Quantity Limits

Ongoing reassessment to establish effective opioid receptor blockade without significant side effects will be performed**.**

- SUBOXONE film 8 mg/2 mg **or** 2 mg/0.5 mg: Max 3 films daily. 4mg/1mg: Max 1 film daily. 12mg/3mg: Max 2 films daily.

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

Signature of Provider **Date**

Please complete the form and fax it to Dani Feist, Pharmacy Program Officer, at (406) 444-1861.