Molina Healthcare of South Carolina
Phone: (855) 237-6178 Fax: (855) 571-3011

OPIOID DEPENDENCE MEDICATION PRIOR AUTHORIZATION FORM

MEMBER INFORMATION		
MEMBER NAME: (LAST, FIRST, MIDDLE INITIAL)	MEMBER ID NUMBER:	DATE OF BIRTH: ____/____/_____

PRESCRIBER INFORMATION			
PRESCRIBER NAME: (LAST, FIRST)	PRESCRIBER SPECIALTY:	10-DIGIT NPI NUMBER:	
OFFICE CONTACT NAME	PHONE NUMBER: ( )	FAX NUMBER: ( )	
ADDRESS	CITY	STATE	ZIP

PRESCRIPTION INFORMATION		
Generic sublingual tablets are preferred and covered without prior authorization up to 24mg per day of buprenorphine.		
MEDICATION *(generic tablets are preferred)*: ☐ **Generic Suboxone tablet** ☐ **Generic Subutex tablet** ☐ Other: _____ *(provide clinical reason tablets cannot be used on page 2 and/or attach)*	STRENGTH:	DIRECTIONS FOR USE:
QUANTITY PER DAY:		
DIAGNOSIS (ICD-10 AND/OR NARRATIVE):		

URINE DRUG SCREEN (UDS) – Required for reauthorization requests		
DATE OF MOST RECENT UDS:		
RESULTS (OR ATTACH LAB REPORT):	POSITIVE	NEGATIVE
OPIOIDS, OPIATES	☐	☐
BENZODIAZEPINES	☐	☐
AMPHETAMINES (***IF POSITIVE, PROVIDE CONFIRMATORY TEST VERIFYING IT IS NOT OF THE ILLICIT TYPE.***)	☐	☐
COCAINE	☐	☐
MARIJUANA	☐	☐
METHAMPHETAMINE (***IF POSITIVE, PROVIDE CONFIRMATORY TEST VERIFYING IT IS NOT OF THE ILLICIT TYPE.***)	☐	☐
BUPRENORPHINE	☐	☐
URINE DRUG SCREEN RESULT IS REQUIRED FOR ALL REQUESTS. FOR POSITIVE RESULTS (EXCEPT BUPRENORPHINE), PLEASE PROVIDE AN EXPLANATION IN THE COMMENTS SECTION ON PAGE 2 (E.G., ALLERGY MEDICATION, ACUTE INJURY, ETC.)		

(CONTINUES ON PAGE 2)

CLINICAL CRITERIA	
INITIAL REQUEST	**RENEWAL REQUEST**
• Has the prescriber met the certification criteria outlined in the Drug Addiction Treatment Act of 2000 and been issued a unique DEA number reflecting this? **PLEASE PROVIDE XDEA NUMBER**: _____ • Does the patient have any uncontrolled psychiatric conditions which would interfere with buprenorphine compliance? ☐ YES ☐ NO • Is the patient receiving counseling and/or other non-pharmacologic therapy as appropriate? ☐ YES ☐ NO • Is the patient taking other opioids, tramadol, benzodiazepines, or carisoprodol? ☐ YES ☐ NO • Is the patient interested in treatment for opioid addiction and capable of understanding the risks and benefits of such treatment, including the risks of using buprenorphine with alcohol or benzodiazepines? ☐ YES ☐ NO • <u>FOR BRAND NAME PRODUCTS</u>: Please document why the member cannot use the preferred generic tablets below. • <u>FOR DOSING GREATER THAN 24MG/DAY OF BUPRENORPHINE</u>: Please provide documentation of the medical necessity of dosing beyond the FDA approved maximum. • <u>FOR SUBUTEX ONLY</u>: Does the patient have a contra-indication to naloxone, such as current pregnancy or historical drug allergy? ☐ YES ☐ NO	• Has the patient been compliant with therapy, as evidenced by random urine drug screen results and reviews of state Prescription Monitoring Program data? ☐ YES ☐ NO • Is the patient enrolled and consistently participating in formal counseling and/or substance abuse counseling with a licensed behavioral health provider since the previous authorization? ☐ YES ☐ NO • Will the patient's treatment goals be assessed at least annually? ☐ YES ☐ NO • What is the treatment plan for the member, including the following information? ❑ For members on chronic (i.e., years) therapy: _____ _____ _____ ❑ If applicable, anticipated dosing and drug tapering schedule for requests greater than 16mg buprenorphine per day: _____ _____ _____

ADDITIONAL INFORMATION / COMMENTS: _____

_____

_____

_____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary for the health of the patient.

_____ _____

PRESCRIBER'S SIGNATURE **DATE**