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United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

ORAL BUPRENORPHINE PRODUCTS

Oral Buprenorphine Products do not require a SA if:

- **It is for a preferred product Suboxone® SL film or buprenorphine/naloxone tablets;**
- **The member must be 16 years of age or older**
- **The prescribed dose must be less than or equal to 24 mg/day**

Length of Authorization: 3 Months (Initial SA), 6 Months (Maintenance SA)
If the following information is not complete, correct, or legible, the SA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DRUG INFORMATION

OPIOID DEPENDENCY – ORAL BUPRENORPHINE

Per the Board of Medicine reg 18VAC85-21-150: DOSES GREATER THAN 24 MG/DAY WILL DENY.

Drug Name/Form: _____

Strength: _____

Quantity per Day: _____

Maximum Quantities for Dose Optimization (Non-Preferred Drugs)

- ☐ buprenorphine/naloxone SL film 2 mg/0.5 mg; 3/day
- ☐ buprenorphine/naloxone SL film 4 mg/1 mg; 1/day
- ☐ buprenorphine/naloxone SL film 8 mg/2 mg; 3/day
- ☐ Zubsolv® SL tab 0.7 mg/0.18 mg; 2/day
- ☐ Zubsolv® SL tab 1.4 mg/0.36 mg; 2/day
- ☐ Zubsolv® SL tab 2.9 mg/0.71 mg; 2/day
- ☐ Zubsolv® SL tab 5.7 mg/1.4 mg; 2/day
- ☐ Zubsolv® SL tab 8.6 mg/2.1 mg; 2/day
- ☐ Zubsolv® SL tab 11.4 mg/2.9 mg; 2/day

TREATMENT INFORMATION

SA Criteria align with Virginia Board of Medicine's Regulations Governing Prescribing of Opioids and Buprenorphine: http://www.dhp.virginia.gov/medicine/

1. Your member's pregnancy has been confirmed by a positive laboratory test?

   ☐ Yes ☐ No

   Buprenorphine mono-product will only be covered for pregnancy for a maximum of 10 months.
   Document expected date of delivery: _____

   (IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless a non-preferred/non-formulary drug is prescribed. See Q4 if non-formulary drug is prescribed.)

2. Does member meet criteria for a diagnosis of Opioid Use Disorder (defined by DSM 5: DSM-5 Criteria for Diagnosis of Opioid Use Disorder)?

   ☐ Yes ☐ No

3. Is the member 16 years of age or older?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

4. **Non-Preferred agents** require documentation as to why the member cannot be prescribed a preferred agent. Include details and a **completed FDA MedWatch Form (https://www.accessdata.fda.gov/scripts/medwatch/index.cfm) is required to be attached for adverse reactions to combination products**.

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826