UnitedHealthcare Community Plan

# Medication Treatment for Substance Abuse Disorders (SUDs)
## Request for Buprenorphine Monotherapy - Washington
### Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.**

**Allow at least 24 hours for review.**

**Section A – Member Information**

| | | |
|---|---|---|
| First Name: | Last Name: | Member ID: |
| Address: | | |
| City: | State: | ZIP Code: |
| Phone: | DOB: | Allergies: |
| Primary Insurance Information (if any): | | |

**Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____**

**Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____**

**Section B - Provider Information**

| | | | | |
|---|---|---|---|---|
| First Name: | | Last Name: | | M.D./D.O. |
| Address: | | City: | State: | ZIP code: |
| Phone: | Fax: | NPI #: | Specialty: | |
| Office Contact Name / Fax attention to: | | | | |

**Section C - Medical Information**

| | |
|---|---|
| **Medication:** | **Strength:** |
| **Directions for use:** | **Quantity:** |
| **Diagnosis** (Please be specific & provide as much information as possible)**:** | **ICD-10 CODE:** |

**Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____**

**Section D – Previous Medication Trials**

| Medication Name | Strength | Directions | Dates of Therapy | Reason for failure / discontinuation |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives**

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| Member First name: | Member Last name: | Member DOB: |
|---|---|---|
| | | |

## Clinical and Drug Specific Information

### ALL REQUESTS

**The following information below MUST be included upon submission:**

□ Medication name, dose, duration □ All supporting labs and chart documentation

### Patient authorization for disclosure of confidential information

The above-named patient hereby authorizes the following entities to exchange and disclose to one another information concerning the patient's name and other personal identifying information, their status as a patient, diagnosis, recommended medication(s) and the treatment recommendation(s):

- The Health Care Authority (HCA)
- Any Managed Care Organization (MCO) contracted by HCA to provide your medical care
- The above named physician.
- The above named pharmacy

**The purpose of this authorization for disclosure is:**

- To initiate an authorization to obtain a prescription and coordinate care.

I understand that my alcohol and/or drug treatment records are protected under Federal and State confidentiality regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

**I also understand** that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: twelve (12) months from the date signed or the **following specific date, event, or condition upon which this consent expires:**

| Patient signature | Date | Guardian or authorized representative signature (if required) | Date |
|---|---|---|---|
| | | | |

### To be completed by prescriber only

□ Patient is pregnant with an estimated delivery date (EDD):_____

Patients approved based on pregnancy will be approved through 30 days after their EDD. When the client is no longer pregnant, transition to a buprenorphine/naloxone combination product is required for ongoing treatment.

□ Naloxone Allergy

**Best practice is to limit patients to a 7 day supply at a time**

Indicate the intended days supply per fill for your patient: 7 day 14 day 28 day

If over a 7 day supply is indicated, is the reason due to transportation complications? Yes No

If no, provide reason: _____

You must attach chart notes documenting a personally observed allergic reaction not attributable to withdrawal.

I have read and understand *Medication Treatment Guidelines for Substance Abuse Disorders (SUDs) – Buprenorphine Containing Products* (http://www.hca.wa.gov/billers-providers/programs-and-services/apple-health-medicaid-drug-coverage-criteria).

| Prescriber signature | Prescriber specialty | Date |
|---|---|---|
| | | |

**Notice Prohibiting Redisclosure of Alcohol or Drug Treatment Information**

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.