Iowa Department of Human Services

Request for Prior Authorization
Buprenorphine/Naloxone

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for oral buprenorphine or buprenorphine/naloxone. Requests for doses above 24 mg per day or greater than once daily dosing will not be considered. Initial requests will be considered for up to 3 months. Requests for maintenance doses above 16 mg per day will not be considered on a long-term basis. Concomitant use with opioids or tramadol will be prohibited. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. Requests for surgically implanted buprenorphine products will not be considered through the pharmacy benefit and should be directed to the member's medical benefit. Payment will be considered when the following is met:

1) Patient has a diagnosis of opioid dependence and meets the FDA approved age; AND
2) Prescriber meets qualification criteria to prescribe buprenorphine/naloxone for opioid dependence and has an "X" DEA number; AND
3) Patient is participating in and compliant with formal substance abuse counseling/psychosocial therapy; AND
4) Documentation the Iowa Prescription Monitoring Program website has been reviewed for the patient's use of controlled substances; AND
5) A projected treatment plan is provided with initial request (see below requirements); AND
6) A treatment plan is provided for patients taking buprenorphine in combination with a benzodiazepine or central nervous system (CNS) depressant (see below requirements); AND
7) Documentation is provided that transmucosal buprenorphine will not be used concomitantly with the buprenorphine implant.
8) Requests for single ingredient buprenorphine will only be considered for pregnant patients.

Requests for renewal must include updated treatment plan and additional documentation as indicated below.

Preferred

☐ Buprenorphine/Naloxone SL Tabs

Non-Preferred

☐ Bunavail
☐ Buprenorphine (Please verify patient is pregnant) ☐ No ☐ Yes
☐ Suboxone SL Film
☐ Zubsolv

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

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Prescriber meets qualifications to prescribe and treat opioid dependence and possess "X" DEA number:
☐ No ☐ Yes

Patient participates in and is compliant with counseling: ☐ No ☐ Yes

Date of most recent counseling session:_____

Is patient using transmucosal buprenorphine with buprenorphine implant? ☐ No ☐ Yes

Initial Requests: Include projected treatment plan. May attach treatment plan or provide at a minimum the below information:

- Anticipated induction/stabilization dose:_____
- Anticipated maintenance dose:_____
- Expected frequency of office visits:_____
- Expected frequency of counseling/psychosocial therapy visits:_____
- Treatment plan for patients taking buprenorphine in combination with a benzodiazepine or CNS depressant:
  - Patient has been educated on the serious risks of combined use? ☐ No ☐ Yes
  - Plan to taper benzodiazepine or CNS depressant if possible: _____

    _____
  - Consideration of alternate anxiety or insomnia treatment options when the benzodiazepine or CNS depressant is used for anxiety or insomnia: _____

    _____
  - Other prescribers involved in the care of the patient are aware of the patient's use of buprenorphine?

    ☐ No ☐ Yes Date contacted: _____
- Documentation the Iowa Prescription Monitoring Program (PMP) website has been reviewed for the patient's use of controlled substances. ☐ No ☐ Yes Date reviewed:_____

Renewal Requests: Please provide the below information:

- Updated treatment plan, including:

  Consideration of a medical taper to the lowest effective dose based on a self assessment scale. Date of most recent taper attempt:_____

  Assessment of concomitant benzodiazepine or CNS depressant use (if applicable):
  - Patient has been educated on the serious risks of combined use? ☐ No ☐ Yes
  - Plan to taper benzodiazepine or CNS depressant if possible: _____

    _____
  - Consideration of alternate anxiety or insomnia treatment options when the benzodiazepine or CNS depressant is used for anxiety or insomnia: _____

    _____
  - Other prescribers involved in the care of the patient are aware of the patient's use of buprenorphine?

    ☐ No ☐ Yes Date contacted: _____

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- Documentation the Iowa Prescription Monitoring Program (PMP) website has been reviewed for the patient's use of controlled substances since the last prior authorization request. ☐ No ☐ Yes
  Date reviewed:_____
- Documentation of a current, negative drug screen. Date of most recent drug screen:_____
- Documentation the patient has been compliant with office visits and counseling/psychosocial therapy visits.
  Compliant with office visits? ☐ No ☐ Yes
  Date of most recent office visit:_____

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*