Opioid Agonist

Brixadi (buprenorphine ER) J0577, J0578, Buprenex (buprenorphine) J0592, Sublocade (buprenorphine XR) Q9991, Q9992, Probuphine (buprenorphine implant) J0570

Prior Authorization Request

Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ New Start or Initial Request: (Clinical documentation required for all requests)

☐ Patient is being treated for opioid dependence; AND

☐ One of the following:

☐ **Both of the following:**

☐ Patient is not currently receiving maintenance buprenorphine treatment; **AND**

☐ Patient has received a test dose of buprenorphine to establish that buprenorphine is tolerated without precipitated withdrawal **OR**

☐ Patient is currently maintained on oral, sublingual, or transmucosal buprenorphine product and Patient has not, nor will receive supplemental, oral, sublingual, or transmucosal buprenorphine; **AND**

☐ Brixadi or Sublocade dosing is in accordance with the U. S. FDA approved labeling;

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ **Continuation Requests: (Clinical documentation required for all requests)**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____ /____ /____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Opioid Agonists (Mixed) PA

Drug Name(s):

BUPRENEX
PROBUPHINE
BRIXADI
SUBLOCADE
BUPRENORPHINE XR
BUPRENORPHINE ER

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Drug is being used appropriately per MCG GUIDELINES, CMS recognized compendia, authoritative medical literature, evidence-based guidelines and/or accepted standards of medical practice.
3. Used as part of a complete treatment plan that includes counseling and psychosocial support or REMS program
4. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approval will be for 12 months

FDA Indications:

Sublocade, Brixadi

- Opioid dependence, Induction of treatment

Buprenex

- Pain (Moderate to Severe)

Probuphine

- Opioid dependence, Maintenance treatment in patients with prolonged clinical stability on low to moderate doses of a transmucosal buprenorphine product

Off-Label Uses:

Buprenex

- Neonatal Abstinence Syndrome

Age Restrictions:

N/A

Other Clinical Considerations:

N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/PFDefaultActionId/evidencexpert.DoIntegratedSearch?navitem=headerLogout

https://careweb.careguidelines.com/ed24/bhg/bhg_05123.htm

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