Pharmacy Prior Authorization

MERCY CARE (MEDICAID)

Sublocade (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Mercy Care at **1-800-854-7614**.
When conditions are met, we will authorize the coverage of Sublocade (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Sublocade (buprenorphine extended-release injection)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 9.]

2. Has a random urine drug screen been completed within 30 days before renewal request? Y N

   Please indicate the date of the most recent random urine drug screen: _____

   [If no, no further questions.]

3. Is the random urine drug screen positive for buprenorphine? Y N

   [If yes, skip to question 5.]

4. Does the provider confirm that member was without the requested medication for a period of time? Y N

   [If no, no further questions.]

5. Is the random urine drugs screen negative for opioids and all other controlled substances? Y N

   [If yes, skip to question 7.]

6. Has the prescriber included a treatment plan that addresses tapering/discontinuation of positive substances? Y N

   [Note: If urine drug screen is positive for controlled substances, the prescriber must include a treatment plan that addresses tapering/discontinuation of positive substances.]

   [If no, no further questions.]

7. Does the prescriber attest that the State Prescription Monitoring Program (PMP) database has been reviewed for other controlled substances? Y N

   Please indicate the most recent date of PMP database review: _____

   [If no, no further questions.]

8. Does the member continue with psychosocial counseling or recovery support? Y N

   [No further questions.]

9. Does the provider attest that the member has an inability to continue use of oral formulations of buprenorphine? Y N

   [If no, no further questions.]

10. Has the member been established on an oral buprenorphine formulation for at least 7 days? Y N

    [If no, no further questions.]

11. Is the member enrolled in, established and compliant with a substance use treatment program or psychosocial support plan? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**