

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**

☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Sublocade[®] (buprenorphine ER injection)

Member

Last Name: _____

First Name: _____

ID #: _____

DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____

Prov. Phone: _____ Prov. Fax: _____

Physician Address: _____

Physician NPI: _____

Contact Name: _____

Physician Signature: _____

Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Sublocade 100 mg-0.5 mL
☐ Sublocade 300 mg-1.5 mL

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose: _____ Dose Frequency: _____

Place of administration: ☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI: _____ Fax: _____

☐ Home infusion

Agency: _____ NPI: _____ Fax: _____

Billing: ☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy: _____ NPI: _____ Fax: _____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Must have a diagnosis of moderate to severe opioid use disorder (OUD)
2. Must be established on oral buprenorphine (e.g., Suboxone, buprenorphine/naloxone) at a dose of 8 to 24 mg (or equivalent*) per day for at least 7 days
3. Must not use supplemental oral buprenorphine while on Sublocade
4. Must be prescribed by a DATA 2000 certified prescriber

***See Additional Information below for dose conversions between oral buprenorphine products**

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New request

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Moderate to severe opioid use disorder (OUD)

☐ Other – the patient's condition is: _____

Rationale for use: _____

B. Has the patient been stabilized on oral buprenorphine at a dose of 8 mg to 24 mg (or equivalent*) per day for at least 7 days?

☐ Yes

☐ No. Rationale for use: _____

C. Will supplemental oral buprenorphine be used with Sublocade?

☐ No.

☐ Yes. Rationale for use: _____

D. Is the prescriber DATA2000 certified?

☐ Yes

☐ No. Rationale for use: _____

Additional information

Note: Sublocade will be limited to 1 injection monthly.