Updated: 02/2020
DMMA Approved: 02/2020

Request for Prior Authorization for Sublocade (buprenorphine extended-release) injection
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Sublocade (buprenorphine extended-release) injection require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Sublocade (buprenorphine extended-release) injection Prior Authorization Criteria:

Members with historical pharmacy claims data meeting the following criteria will receive automatic authorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the criteria. Claims will automatically adjudicate on-line, without a requirement to submit for prior authorization when the following criteria is met:

For all requests for Sublocade (buprenorphine extended-release) injection all of the following criteria must be met:

- Prescription Monitoring Program will be checked prior to each injection to insure a transmucosal formulation has not been prescribed by another practitioner
- For initial authorization, the member must have had an oral formulation of a buprenorphine-containing product through outpatient pharmacy, inpatient administration, or medication-assisted treatment program (opioid treatment program) within the past 14 days.
- The prescriber attests that member is not receiving both the buccal and injectable formulations of buprenorphine simultaneously.
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

HIGHMARK. Delaware HEALTH OPTIONS

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SUBLOCADE (BUPRENORPHINE EXTENDED-RELEASE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

1. Will the Prescription Monitoring Program (PMP) be checked prior to each injection to insure buccal formulation has not been prescribed by another practitioner? ☐ Yes ☐ No
2. Does the prescriber attest that the member is not receiving both the buccal and injectable formulations of buprenorphine simultaneously? ☐ Yes ☐ No
3. Has the member had an oral formulation of a buprenorphine-containing product through outpatient pharmacy, inpatient administration, or medication-assisted treatment program (opioid treatment program) within the past 14 days? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date