Updated: 02/2019
PARP Approved: 02/2019

Gateway Health
Prior Authorization Criteria
Buprenorphine Sublingual Tablets

All requests for Buprenorphine Sublingual Tablets require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Buprenorphine Sublingual Tablets Prior Authorization Criteria:

Coverage may be provided with a diagnosis of Opioid Use Disorder and the following criteria is met:

- The member is 16 years of age or older
- The member is pregnant, breast feeding, or is undergoing induction therapy with the intent to covert to Suboxone Film in 4 weeks or less
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- If the member is taking buprenorphine in combination with a benzodiazepine or CNS depressant, documentation of **ONE** of the following must be submitted:
    - A tapering plan for the benzodiazepine or CNS depressant **AND** provider attestation the member has been educated about the serious risks of combined use, including overdose and death, that can occur with CNS depressants even when used as prescribed, as well as when used illicitly (if applicable)
    - Attestation of a urine or blood drug screening within the last 3 months **AND** attestation the provider has verified the member is receiving prescribed benzodiazepines or other CNS depressants for anxiety or insomnia, concomitant use with these agents is medically necessary, and alternative treatment options for these conditions were tried and failed, contraindicated, or inappropriate
- Documentation the prescriber or the prescribing provider's delegate has conducted a search of the Pennsylvania Prescription Drug Monitoring Program (PDMP) for the recipient's controlled substance prescription history before prescribing buprenorphine treatment.
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria:**
    - Buprenorphine SL tablets is considered medically necessary and will be reauthorized for treatment of opioid use disorder through the dispensing pharmacy when the following criteria is met:
        - The provider attests the member is still pregnant or breast feeding.
- **Reauthorization Duration of Approval:** 6 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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BUPRENORPHINE SUBLINGUAL TABLETS
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 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:
Gateway 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:

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)

Diagnosis: _____ ICD-10 Code: _____

Is the member pregnant, breast feeding, or undergoing induction therapy with the intent to covert to Suboxone Film in 4 weeks or less? ☐ Yes ☐ No

Is the member concurrent taking a benzodiazepine or CNS depressant? ☐ Yes ☐ No

If yes, please check the applicable boxes:

☐ The member has been educated about the serious risks of combined use, including overdose and death, that can occur with CNS depressants even when used as prescribed, as well as when used illicitly (if applicable)
☐ A tapering plan for discontinuation of the benzodiazepine or CNS depressant is provided
☐ The member is receiving benzodiazepines or other CNS depressants for anxiety or insomnia, concomitant use with these agents is medically necessary, and alternative treatment were tried and failed or inappropriate (document in section below)
☐ A urine or blood drug screen within the past 3 months is provided

Has the member's Prescription Drug Monitoring Program (PDMP) prescription history been reviewed? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

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MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REAUTHORIZATION

Is the member currently pregnant or breastfeeding? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date