Commonwealth of Massachusetts
**MassHealth Drug Utilization Review Program**
P.O. Box 2586, Worcester, MA 01613-2586
**Fax:** (877) 208-7428 **Phone:** (800) 745-7318

Print Clear

# Opioid Dependence and Reversal Agents Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

## Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

## Medication information

**Medication requested**

| | | | |
|---|---|---|---|
| ☐ Bunavail (buprenorphine/naloxone buccal film) | ☐ 2.1 mg/0.3 mg | ☐ 4.2 mg/0.7 mg | ☐ 6.3 mg/1 mg |
| ☐ buprenorphine tablet | ☐ 2 mg | ☐ 8 mg | |
| ☐ buprenorphine/naloxone film | ☐ 2 mg/0.5 mg<br>☐ 12 mg/3 mg | ☐ 4 mg/1 mg | ☐ 8 mg/2 mg |
| ☐ buprenorphine/naloxone tablet | ☐ 2 mg/0.5 mg | ☐ 8 mg/2 mg | |
| ☐ Lucemyra (lofexidine) | | | |
| ☐ Probuphine (buprenorphine implant) | | | |
| ☐ Sublocade (buprenorphine extended-release injection) | ☐ 100 mg/0.5 mL | ☐ 300 mg/1.5 mL | |
| ☐ Zubsolv (buprenorphine/naloxone tablet) | ☐ 0.7 mg/0.18 mg<br>☐ 5.7 mg/1.4 mg | ☐ 1.4 mg/0.36 mg<br>☐ 8.6 mg/2.1 mg | ☐ 2.9 mg/0.71 mg<br>☐ 11.4 mg/2.9 mg |

**Dose, frequency, and duration of requested drug** _____

For all requests for medications containing buprenorphine, is the member maintained on the lowest effective dose?

☐ Yes ☐ No. If no, please provide complete treatment plan. _____

**Indication** (Check all that apply.)

☐ Management of opioid withdrawal symptoms ☐ Opioid dependence ☐ Other (specify) _____

## Section I. Please complete the following for all requests.

1. Please indicate billing preference. ☐ Pharmacy ☐ Prescriber in-office ☐ Hospital outpatient
   For hospital outpatient billing, provide department-specific facility NPI _____
2. Drug NDC (if known) or service code _____
3. Has the prescriber evaluated the Massachusetts Prescription Awareness Tool (MassPAT) data? ☐ Yes ☐ No
4. Does the prescriber have a relationship to refer the member to counseling or care management?
   ☐ Yes ☐ No. MassHealth will offer this member care management services.

**Section II. Please complete for buprenorphine tablet requests.**

1. Is the member pregnant? ☐ Yes. Anticipated date of delivery _____ ☐ No
2. Is the member breastfeeding? ☐ Yes ☐ No
3. Does the member have a documented allergy to naloxone? ☐ Yes ☐ No
   If yes, please provide medical records documenting the allergic reaction.
4. If you answered "No" to the three questions above, please provide medical necessity for prescribing buprenorphine rather than buprenorphine/naloxone. (Please explain below and provide medical records.)

_____

_____

**Section III. Please complete for buprenorphine, buprenorphine/naloxone film, and buprenorphine/naloxone tablet doses exceeding 24 mg/day, Bunavail doses exceeding 12.6 mg/day, and Zubsolv doses exceeding 17.2 mg/day.**

Please document medical necessity for high dose of buprenorphine/naloxone and buprenorphine below and submit medical records supporting the medical necessity provided.

_____

_____

**Section IV. Please complete for Bunavail, buprenorphine/naloxone tablets, and Zubsolv requests.**

Has the member had an allergic reaction to buprenorphine/naloxone film?

☐ Yes. (Specify and provide medical records.)

_____

☐ No. Please explain.

_____

**Section V. Please complete for Probuphine requests.**

1. Is the member currently stabilized on ≤ 8 mg buprenorphine or equivalent dosed formulation for at least six months? ☐ Yes ☐ No
2. Please describe medical necessity for use of the implanted formulation.

   _____

   _____
3. Please attach medical records documenting an allergic reaction, contraindication, or inadequate response to all other clinically appropriate therapeutic alternatives.

**Section VI. Please complete for Sublocade requests.**

1. Has the member been stabilized on buprenorphine at a dose of ≤ 24 mg per day for at least seven days? ☐ Yes ☐ No
2. Please describe medical necessity for use of the extended-release injection formulation.

   _____

   _____

**Section VII. Please complete for Lucemyra requests.**

Has the member had a trial with oral clonidine?

☐ Yes. Please list the dose and frequency, dates/durations of use, and outcomes below.

Dose and frequency _____ Dates/duration of use _____

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response ☐ Other

Briefly describe details of adverse reaction, inadequate response, or other.

_____

over

☐ No. Please describe clinical rationale why the member is not a candidate for oral clonidine.

_____

## Section VIII. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

## Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

## Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

**Signature required** _____

Printed name of prescribing provider _____ Date _____