Prior Authorization Form
Buprenorphine Products

Division of TennCare

Optum Rx®

**PLEASE NOTE: ALL BUPRENORPHINE OR BUPRENORPHINE/NALOXONE REQUESTS MUST BE SUBMITTED VIA FAX or ePA.

Member Information (REQUIRED)			Prescriber Information (REQUIRED)		
Member Name:			Provider Name:		
Insurance ID #:			NPI #:		
Date of Birth:			DEA #:	Specialty:	
Street Address:			Office Phone:	Office Fax:	
City:	State:	Zip:	Supervising Physician and DEA # (if applicable):		
Phone:			Office Street Address:		
			City:	State:	Zip:
			Is the prescriber a TennCare provider with a Medicaid ID? ☐ Yes ☐ No Is the prescriber a single-patient contract holder for this patient? ☐ Yes ☐ No		

***** To be in the TennCare Buprenorphine Enhanced Supportive Medication-Assisted Recovery and Treatment (BESMART) network, the provider must have a separate BESMART contract with the Managed Care Organizations (MCOs). *****

PLEASE READ: Nurse Practitioners (NP) and Physician Assistants (PA) seeking to prescribe buprenorphine-containing products to TennCare members must be a BESMART Provider. Requests from NPs and PAs not contracted in the BESMART Network will be denied. Please answer the following questions to determine if you are eligible to prescribe these medications for TennCare patients:

1. What is your provider type?
   ☐ Physician (MD, DO) ☐ Nurse Practitioner (NP) ☐ Physician Assistant (PA)
2. Are you contracted with at least one TennCare MCO as a BESMART Network Provider **and** attested to the Program Description?
   ☐ Yes ☐ No
   a. If **YES**, provider is eligible to prescribe buprenorphine medications. Complete the BESMART network section of the prior authorization form.
   b. If **NO**, only physicians are eligible to prescribe. Complete the non-BESMART Network section of the form.

IF YES TO THE QUESTION ABOVE:

TennCare BESMART Network Provider ONLY

Requested Buprenorphine Product

Preferred	Non-Preferred
☐ **Buprenorphine/naloxone SL Tablet** ☐ **Buprenorphine/naloxone Film** **(Please note: Preferred medications do not require a PA for doses up to 16 mg per day)**	☐ **Buprenorphine mono** ☐ **Suboxone® Film** Indication: ☐ Pregnancy/breastfeeding -- Estimated due date or actual delivery date (required): _____ ☐ Allergy to naloxone (Documentation required) ☐ Other: _____ **Complete Question 4 on Page 2.**

1. Requested Strength: _____

2. Number of Units/Day: _____

3. Rx Directions: _____

4. Total Number of Units/Rx: _____

IF NO TO THE QUESTION ABOVE:

All Other TennCare Prescribers

Requested Buprenorphine Product

Preferred	Non-Preferred
☐ **Buprenorphine/naloxone SL Tablet** **(Please note: Preferred medications do not require a PA for initial 5 day supply of up to 16 mg per day if patient has no paid claims for buprenorphine in the last 180 days.)**	☐ **Buprenorphine mono** ☐ **Buprenorphine/naloxone Film** ☐ **Suboxone® Film** Indication: ☐ Pregnancy/breastfeeding--Estimated due date or actual delivery date (required): _____ ☐ Allergy to naloxone (Documentation required) ☐ Other: _____ **Complete Question 14 on page 4.**

1. Requested Strength: _____

2. Number of Units/Day: _____

3. Rx Directions: _____

4. Total Number of Units/Rx: _____

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TennCare BESMART Network Provider

NOTE: For induction and stabilization/maintenance therapy phases in adults, TennCare covers **up to 16 mg per day** when product selected is Suboxone® or generic equivalents. Please answer the questions below if request is for non-preferred product or for doses greater than 16 mg per day.

Based on the information above, will the recipient be using a larger daily dose/quantity than TennCare covers? ☐ **Yes** ☐ **No**
******If yes, please answer question 5 below******

1. Are you a contracted with at least one TennCare MCO as a BESMART provider, attested to the MAT Program Description and have a valid TennCare ID? ☐ Yes ☐ No
   If No, skip to the "All other prescribers" section.
2. Diagnosis: ☐ Treatment of opiate addiction/OUD ☐ Other: _____
3. Will buprenorphine be used for treatment of depression or pain? ☐ Yes ☐ No
4. If requesting a non-preferred agent, please submit documentation of allergy to inactive ingredient in preferred product that is not in the requested product and any other information pertinent to this prior authorization request:
   _____
   _____

IF REQUESTING ABOVE THE QUANTITY LIMIT OF 16 MG/DAY for buprenorphine-containing products, complete question 5.

5. Please provide a clinical rationale for the requested dosage with one of the following reasons:
   ☐ Pregnant patients confirmed by provider attestation. (Please provide estimated due date: _____)
   ☐ Postpartum patients for a period of 12 months from delivery date. (Please provide delivery date: _____)
   ☐ Recent intravenous drug users confirmed by prescriber attestation and a positive drug screen.
   ☐ Current users receiving greater than 50 mg of methadone for OUD treatment transitioning to buprenorphine agonist therapy. *Please provide paid claims data from the enrollee's health insurer, provider attestation, or medical records.*
   ☐ Newly eligible TennCare enrollees (within the past 60 days) who are current users of 16 mg to 24 mg per day of buprenorphine. *Please provide paid claims data from enrollee's previous health insurer.*

******If the most recent prior authorization approval for buprenorphine/naloxone or buprenorphine was requested by a different prescriber, please ensure transfer of care has occurred. ******

Prescriber Signature (Required) **Date**

By signature, the prescriber has attested to the BESMART Program Description and requirements (i.e. check CSMD, provide care coordination, ensure access to counseling services)

Fax this form to 1-866-434-5523
Phone: 1-866-434-5524
OptumRx will provide a response within 24 hours upon receipt.

TN Division of TennCare

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IMPORTANT! Nurse Practitioners and Physician Assistants not contracted in the BESMART Provider Network are not eligible to prescribe buprenorphine medications. Requests received will be denied.

All Other TennCare Prescribers
(Excluding Nurse Practitioners and Physician Assistants)

NOTE: For induction therapy in adults, TennCare covers up to 16 mg per day when product selected is Suboxone® or generic equivalents for 6 months. During stabilization/maintenance phases, coverage is reduced to a max of 8 mg per day for Suboxone® or generic equivalents.

Based on the information above, will the recipient be using a larger daily dose/quantity than TennCare covers? ☐ **Yes** ☐ **No**

1. Is the prescriber a TennCare provider with a Medicaid ID? ☐ Yes ☐ No
2. Is the prescriber a single-patient contract holder for this patient? ☐ Yes ☐ No
3. Diagnosis: ☐ Treatment of opiate addiction ☐ Other:_____
4. Will buprenorphine be used for the treatment of depression or pain? ☐ Yes ☐ No
5. Controlled Substance Monitoring Database (CSMD) check is required on date of request. Do you attest that you comprehensively reviewed the last six (6) months in the CSMD for this patient on the date of the prior authorization request? ☐ Yes ☐ No
6. **IF RECIPIENT IS BEGINNING BUPRENORPHINE MEDICATION ASSISTED THERAPY, *complete question 6*.**
   (If continuing therapy, skip to #8)
   Projected Treatment Plan *(MUST complete entire section, and then skip to question #11):*
   a) Anticipated Induction/Stabilization dose (Target < 16mg/day): _____ mg Start Date: _____
   b) Anticipated Maintenance dose (Target ≤ 8mg/day): _____ mg Start Date: _____
   c) Expected frequency of office visits: _____ Start Date: _____
   d) Expected frequency of counseling/psychosocial therapy visits: _____ Start Date: _____
   e) Name of Practitioner who will be providing counseling: _____

IF PATIENT HAS RECEIVED any buprenorphine-containing product IN THE LAST SIX MONTHS, complete questions 7-10.

7. Has the recipient had any concomitant opioid usage since last prior authorization approval for buprenorphine/naloxone or buprenorphine, or in previous 3 months? ☐ Yes ☐ No

7a. IF YES to question 7, prescriber attests that concurrent opioids have been discontinued, retrieved, or destroyed. ☐ Yes ☐ No

8. Has the recipient had any concomitant benzodiazepine usage since last prior authorization approval for buprenorphine/naloxone or buprenorphine, or in previous 3 months? ☐ Yes ☐ No

8a. IF YES to question 8, prescriber attests that concurrent benzodiazepines have been discontinued, retrieved, or destroyed. ☐ Yes ☐ No

9. Has the recipient demonstrated compliance with counseling visits since last prior authorization approval for buprenorphine/naloxone or buprenorphine, or in previous 3 months? ☐ Yes ☐ No

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10. Was the most recent prior authorization approval for buprenorphine/naloxone or buprenorphine requested by a different prescriber? ☐ Yes ☐ No

IF YES, *please answer 10a-10c:*

10a. Prescriber Name: _____

Contact: _____

10b. Is this prescriber in your practice group? (If yes, skip to next question. If no, go to question 10c) ☐ Yes ☐ No

10c. Have you contacted this prescriber and successfully transitioned care to your practice? ☐ Yes ☐ No

IF REQUESTING ABOVE THE QUANTITY LIMIT (16 MG/DAY for first 6 months of therapy; 8 MG/DAY thereafter) for buprenorphine-containing products, complete questions 11-14 below.

11. Is the recipient being treated for an initial induction/stabilization phase? ☐ Yes ☐ No

12. Is the recipient being actively treated for opioid addiction and has concomitant need for non-recurring short-term pain management? ☐ Yes ☐ No

13. Is the recipient pregnant, or has she been pregnant while receiving buprenorphine during the last 6 months? ☐ Yes ☐ No

13a. **If YES,** please provide pregnancy due date or actual delivery date:_____

14. If requesting a non-preferred agent, please submit documentation of allergy to inactive ingredient in preferred product that is not in the requested product and any other information pertinent to this prior authorization request.

_____

_____

_____

_____

_____ _____

Prescriber Signature (Required) **Date**

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

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