# Prior Authorization Form
## Buprenorphine Products

Access this PA form at: https://optumrx.com/oe_tenncare/prescriber

**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#: | X–DEA# (Required): |
| Date of Birth: | | | DEA# (Required): | 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<br>Is the prescriber a single-patient contract holder for this patient? ☐ Yes ☐ No | |

*****To be a TennCare MAT Network provider or Buprenorphine Medication Assisted Treatment (BMAT) provider, the provider must have a separate MAT 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 TennCare MAT Provider. Requests from NPs and PAs not contracted in the MAT 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 MAT Network Provider or Buprenorphine Medication Assisted Treatment (BMAT) provider **and** attested to the MAT Program Description? ☐ Yes ☐ No
   a. If **YES**, provider is eligible to prescribe buprenorphine medications. Complete the MAT network section of the prior authorization form.
   b. If **NO**, only physicians are eligible to prescribe. Complete the non-MAT Network section of the form.

**IF YES TO THE QUESTION ABOVE:**

**TennCare MAT Network Provider- ONLY***

**Requested Buprenorphine Product**

| Preferred | Non-Preferred |
|---|---|
| ☐ **Bunavail®**<br>☐ **Buprenorphine/naloxone SL Tablet**<br>☐ **Buprenorphine/naloxone Film** | ☐ **Buprenorphine mono**<br>Indication:<br>☐ Pregnancy ☐ Allergy to naloxone (documentation required)<br>☐ Other:_____<br>***Please complete question # 6 on page 3.** |

1. **Requested Strength:**
2. **# of Units per Day:**_____
3. **Directions for use:**_____
4. **Total # of Units Per Prescription:**_____
5. **If dosing other than "Once Daily", please provide clinical rationale:**_____

**IF NO TO THE QUESTION ABOVE:**

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

**Requested Buprenorphine Product**

| Preferred | Non-Preferred |
|---|---|
| ☐ **Bunavail®**<br>☐ **Buprenorphine/naloxone SL Tablet** | ☐ **Buprenorphine mono**<br>Indication:<br>☐ Pregnancy ☐ Allergy to naloxone (documentation required)<br>☐ Other:_____<br>***Please complete question 15 on page 6.** |

1. **Requested Strength:**
2. **# of Units per Day:**_____
3. **Directions for use:**_____
4. **Total # of Units Per Prescription:**_____
5. **If dosing other than "Once Daily", please provide clinical rationale:**_____

***NOTE:** For induction therapy in adults, TennCare covers up to 8.4 mg of buprenorphine per day when product selected is Bunavail®, and up to 16 mg per day when product selected is Suboxone®, Subutex®, or generic equivalents for 6 months. During stabilization/maintenance phases, coverage is reduced to a max of 4.2 mg of buprenorphine per day for Bunavail®, and 8 mg per day for Suboxone®, Subutex®, or generic equivalent.*

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

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**IMPORTANT! If not a TennCare contracted MAT provider, please continue on the next page.**

## TennCare MAT Network Provider- ONLY

1. Are you a contracted with at least one TennCare MCO as a MAT Network Provider or Buprenorphine Medication Assisted Treatment (BMAT) 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 active opiate addiction/OUD ☐ Other:_____

3. Will buprenorphine be used for treatment of depression or pain? ☐ Yes ☐ No

4. Was the most recent prior authorization approval for buprenorphine/naloxone or buprenorphine requested by a different prescriber if previous prior authorization was obtained through TennCare? ☐ Yes ☐ No ☐ Not applicable- patient has not received previously
   ***IF YES,*** *please answer 4a-4b:*
   4a. Prescriber Name:_____ Contact:_____
   4b. Is this prescriber in your practice group? ☐ Yes ☐ No

***IF REQUESTING ABOVE THE QUANTITY LIMIT*** *for buprenorphine containing products, complete questions 5a-5d.*

5. Quantity Limit Requests:
   5a. Is the recipient being treated for an initial induction/stabilization phase? ☐ Yes ☐ No

   5b. Is the recipient being actively treated for opioid addiction and has concomitant need for non-recurring short-term pain management? ☐ Yes ☐ No
   ***If YES,*** *MUST list diagnosis requiring non-recurring short-term pain management:*
   _____

   5c. Is the recipient pregnant, or has she been pregnant while receiving buprenorphine during the last 6 months? ☐ Yes ☐ No
   ***If YES,*** *pregnancy due date:*_____

   5d. Has the recipient experienced a relapse? ☐ Yes ☐ No
   ***If YES,*** *is recipient being re-initiated on therapy?* ☐ Yes ☐ No

6. 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 attested to the MAT Program Description and requirements (e.g. 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**

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## Buprenorphine Products

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

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

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 active opiate addiction ☐ Other:_____
4. Will buprenorphine be used for the treatment of depression or pain? ☐ Yes ☐ No
5. Is this prescription written under the "X" DEA Number such that this patient counts towards the patient limits established for individual physicians by the DATA 2000 waiver? ☐ Yes ☐ No
6. Controlled Substance Monitoring Database (PDMP) check is required on date of request. Do you attest that you comprehensively reviewed the last six (6) months in the PDMP for this patient on the date of the prior authorization request? ☐ Yes ☐ No
7. **IF RECIPIENT IS BEGINNING BUPRENORPHINE MEDICATION ASSISTED THERAPY**
   *(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 PRODUCT IN THE LAST SIX MONTHS**, complete questions 8-11.*

8. 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

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

9. 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

   9a. IF YES to question 9, prescriber attests that concurrent benzodiazepines have been discontinued, retrieved or destroyed. ☐ Yes ☐ No

   9b. If no to question 9a, please write the plan for tapering the patient off of benzodiazepines: _____

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10. 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

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

***IF YES,*** *please answer 11a-11c:*

11a. Prescriber Name: _____ ☐ Yes ☐ No
Contact: _____

11b. Is this prescriber in your practice group? (If yes, skip to next question. If no, go to question 11c) ☐ Yes ☐ No

11c. Have you contacted this prescriber and successfully transitioned care to your practice? ☐ Yes ☐ No

***IF REQUESTING ABOVE THE QUANTITY LIMIT*** *for buprenorphine containing products, complete questions 12-14 (Otherwise, skip to Question 15).*

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

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

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

*14a.* ***If YES,*** *pregnancy due date:*_____

15. 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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