CareSource PASSE

Arkansas Medicaid Medication Assisted Treatment (MAT) Pharmacotherapy
Sublocade® (buprenorphine SQ Injection)
VIVITROL® (naltrexone ER IM injection)
Statement of Medical Necessity

After completion of this form, please fax to the CareSource PASSE™ Pharmacy Program at **1-866-930-0019**.

Request Date

☐☐ / ☐☐ / ☐☐☐☐ Non-Urgent ☐ Urgent ☐

CareSource PASSE Provider National Provider Identifier (NPI)	CareSource PASSE Beneficiary ID Number
Prescriber Name	Beneficiary Name
Prescriber Street Address	Beneficiary Street Address
City State ZIP	City State ZIP
Prescriber Phone	Patient's Date of Birth
Prescriber Fax	Benefit this claim is billed under: Pharmacy ☐ Medical ☐
Office Contact (for any additional information needed with Prior Authorization (PA) processing)	

Medication Requested

☐ VIVITROL® 380 mg IM Injection *Quantity Edits Apply
☐ Sublocade® 100 mg SQ
☐ Sublocade® 300 mg SQ

Per SAMHSA - Medication-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

Vivitrol® PA request (Once the following information is provided, the PA can be approved for six months):

a. Indicate reason for PA request for VIVITROL® IM injection:

Opioid Use Disorder	YES ☐	NO ☐
Alcohol Use Disorder	YES ☐	NO ☐
Mixed Opiate/Alcohol Dependence	YES ☐	NO ☐

b. Did the beneficiary have evidence of oral naltrexone tolerability? YES ☐ NO ☐

c. Provide current chart notes;

d. Provide liver function test results (VIVITROL® IM is not approved for Child-Pugh C classification); **AND**

e. Provide the current urine drug screen test results (specifically testing for opioids).

Sublocade® PA request (Once the following information is provided, the PA can be approved for 6 months):

a. Do you attest that this patient is being treated for opioid use disorder? YES ☐ NO ☐

b. Did the beneficiary have induction with a buprenorphine-containing product for a least 7 days?
YES ☐ NO ☐

c. Provide current chart notes; **AND**

d. Provide current urine drug screen test results (specifically testing for opioids).

Prescriber Signature: _____ **Date:** _____

Prescriber's original signature required; copied, stamped, or e-signature are not allowed. By signature the prescriber confirms the criteria information above is accurate and verifiable in patient records.