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Rev. 05.09.2017

Kentucky Medicaid Substance Use Treatment Pharmacy Prior Authorization Form For Buprenorphine Products

- **Buprenorphine Product prior authorizations for substance use treatment can ONLY be requested by AUTHORIZED PHYSICIANS using This Form.**
- **For Pain Management - Please use the Kentucky Medicaid Pharmacy Prior Authorization Form (only limited buprenorphine products are approved for pain management).**

Length of authorization: Induction Request: Ten (10) days' supply for three (3) fills, followed by fourteen (14) days' supply for two (2) fills; Maintenance Request: Six (6) months

Complete each section legibly and completely. Include any supporting documents as needed (lab results, chart notes, etc.).

Please fax completed form to the corresponding fax number of the health plan partner your patient is currently enrolled. Additional prior authorization forms can be found by clicking on hyperlinks provided to the right.

Plan:	Phone number:	Fax number:
☐ Fee-For-Service (Magellan)	1 (800) 477-3071	1 (800) 365-8835
☐ Anthem Medicaid	1 (855) 661-2028	1 (855) 875-3627
☐ Aetna Better Health	1 (855) 300-5528	1 (855) 799-2550
☐ Humana CareSource	1 (855) 852-7005	1 (866) 930-0019
☐ Passport Health Plan	1 (844) 380-8831	1 (844) 802-1406
☐ WellCare of Kentucky	1 (877) 389-9457	1 (855) 620-1868

I. Member Information

Member Name:	Date of Birth:
Member ID:	Sex: ☐ Male ☐ Female
Address: City, State, Zip:	Phone:

II. Prescriber Information

Name:	DEA:
Office Contact Name: Office Address: City, State, Zip: Phone:	**XDEA**: NPI: FAX:

1. Prescriber is enrolled as a valid Medicaid prescriber? ☐ Yes ☐ No
2. Prescriber certifies they are treating the patient for a substance use disorder and billing Medicaid for such service(s) through the member's health plan? ☐ Yes ☐ No
3. Prescriber is compliant with all stipulations in the practice act regulation **(201 KAR 9:270)** when dispensing buprenorphine products? ☐ Yes ☐ No

III. Diagnosis Criteria

Diagnosis: **ICD-10 Code:**

1. Patient has signed an informed consent or treatment contract? ☐ Yes ☐ No
2. Patient's treatment plan includes at least once monthly visits with the treating physician within first two (2) years of care or at least once every three (3) months with documentation of compliance history of two (2) years plus? ☐ Yes ☐ No
3. Prescriber has explained treatment alternatives and the risks and benefits of using buprenorphine containing products to the patient, along with the risk of using these products with alcohol, stimulants, other opioids, or benzodiazepines? ☐ Yes ☐ No

Other Relevant Diagnoses:

Please indicate whether this is a: ☐ **INITIAL Request** ☐ **REAUTHORIZATION (REFILL) Request with current plan**

Check One: ☐ Induction ☐ Maintenance **Induction Date** (required):

IV. REQUESTED BUPRENORPHINE PRODUCT

Medication Requested:		
Directions for Use:		
Dosage Strength Requested:	Quantity:	Total mg Per Day:
Days' Supply:	Duration of Therapy:	

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BUPRENORPHINE SINGLE INGREDIENT REQUESTS ONLY: (clinical criteria must meet all initial criteria and **ONE (1)** of the following)

Check One: ☐ Patient pregnant ☐ Two (2) day induction ☐ Naloxone hypersensitivity

Required for Review: Documentation illustrating hypersensitivity reaction to naloxone, if applicable.

Female Patients Only:

1. Is the patient pregnant or nursing? ☐ Yes ☐ No

   If **YES,** prescriber must be certified in addiction medicine, psychiatry, obstetrics, or maternal-fetal medicine by the American Board of Addiction Medicine (ABAM), the American Board of Medical Specialties (ABMS), or an American Osteopathic Association (AOA) certifying board **OR** documentation must be submitted stating that the prescriber has consulted with such a certified provider.

2. Has patient been counseled on the risks of neonatal abstinence syndrome? ☐ Yes ☐ No

   Required for Review: Documentation of recent pregnancy test or inability to conceive and/or documentation of counseling as to the risk of neonatal abstinence syndrome by a certified prescriber.

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V. INITIAL TREATMENT REQUESTS ONLY (if request is for continuation therapy skip to Section VI)

1. Prescriber has performed induction protocol and has documented opioid withdrawal. ☐ Yes ☐ No
2. Has prescriber identified any opioid, benzodiazepine, sedative, or stimulant prescribed medications fourteen (14) days prior to requested initiation of buprenorphine therapy? ☐ Yes ☐ No If yes, have they been discontinued? ☐ Yes ☐ No
   If no, please refer to criteria for documentation that must be submitted for approval. For concomitant use, the prescriber must be certified through the American Board of Addiction Medicine (ABAM), the American Board of Medical Specialties (ABMS) in psychiatry, the American Osteopathic Association (AOA) certifying board in addiction medicine or psychiatry, OR if not, they have consulted with such a certified practitioner. Please document your specialty or the name and specialty of consulted prescriber or document acute medical need and days supply of less than or equal to thirty (30) days.
3. Prescriber has included documentation of an initial assessment and full treatment plan including acceptable documentation of monitoring, lab tests, drug screens, and behavioral and psychosocial therapy drug abuse counseling services? ☐ Yes ☐ No
   Include induction phase and titration schedule proposed to determine the appropriate level of dosage, a stabilization phase leading to a step down tapering phase, and a discontinuation phase or evidence and support for continued use, and counseling documentation (see Section VII below).
4. Prescriber has included documentation that the patient is being referred or already started receiving behavioral and psychosocial therapy services? ☐ Yes ☐ No
5. Prescriber has obtained the KASPER report no earlier than two (2) days prior to the date of this request? ☐ Yes ☐ No

KASPER Request Number:	Date Last Queried:	Number of Concomitant Narcotic Prescriptions:	Date of Last Controlled Substance Filled:

Initial KASPER should include controlled substance fill history for last twelve (12) months.

VI. REAUTHORIZATION (REFILL) REQUESTS ONLY (with current plan)

1. The prescriber has previously submitted all required initial treatment documentation? ☐ Yes ☐ No
2. The prescriber has included documentation of negative urine tests since previous authorization (minimum screen shall include buprenorphine, methadone, opioids, THC, benzodiazepines, stimulants, cocaine)? ☐ Yes ☐ No
   All urine drug screens since previous authorization must be provided (indicate those that were random) to be considered a complete request.
3. Patient has been compliant with **NO GAPS** in therapy since initial authorization? ☐ Yes ☐ No (if no, attach explanation)
4. The prescriber has included documentation that demonstrates evaluation of patient's dosage and/or appropriation chart documentation and clinical reasoning for continuation? ☐ Yes ☐ No (dose evaluations are required every three (3) months after initial fill at 4mg or greater)
5. The patient has continued active participation in evidence based drug abuse counseling methods? ☐ Yes ☐ No (**attach documentation**) **Note:** For established patients with no session in the past month, approval will be granted for one (1) month if all other criteria is met, and no additional fills shall be approved until counseling has resumed.

Required for review: Documentation of all monitoring tools (urine analysis/drug screen) including medication compliance checks that occurred prior to or in between requests. Any abnormal findings must be explained.

Complete the information below regarding KASPER reports: (each report prior to the last PA submitted must be listed; these should be run monthly)

Report #	Query Date	KASPER Request Number	Report #	Query Date	KASPER Request Number
1			3		
2			4		

Current dose – patient's current milligram (mg) daily dose is: _____ mg daily

Dose evaluation (every twelve (12) months) – must be completed if dose is greater than 16 mg daily:
Is prescriber certified through the American Board of Addition Medicine (ABAM), the American Board of Medical Specialties (ABMS) in psychiatry, or the American Osteopathic Association (AOA) certifying board in addiction medicine or psychiatry? ☐ Yes ☐ No
If no, has prescriber referred patient to such a certified prescriber? ☐ Yes ☐ No
Please document your specialty or the name and specialty of consulted prescriber or document acute medical need and days supply of less than or equal to thirty (30) days. If both no, request must be denied.

VII. COUNSELING DOCUMENTATION (the following must be submitted with each PA request)

Required for Review: Documentation of the physician rendering counseling must be submitted with each request if the prescribing physician is not a psychiatrist or certified addiction specialist. If another physician is providing counseling, a letterhead from that individual must be submitted confirming the patient is undergoing active counseling (including objective psychosocial and behavioral modification).

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Other Pertinent Information: **(attach additional pages if needed)** _____ _____
I attest, by signature, that the above information is true and accurate to the best of my knowledge and has been documented appropriately in the patient's medical records.

Prescriber Signature:	Date: