MAGELLAN COMPLETE CARE

Prior Authorization

Suboxone®/Subutex®

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number ___ - ____

Prescriber Fax Number ___ - ____

Complete this section for initiation and continuation: **(Refer to page 2 for required documents and the prescriber's signature)**

Check one: ☐ Suboxone® ☐ Subutex® Dose: _____ Directions: _____

Check one: ☐ Induction ☐ Stabilization ☐ Maintenance **Induction date** (required): _____

Anticipated length of therapy:

1. Is the patient pregnant or nursing? ☐ Yes ☐ No
   Expected date of delivery:
2. Is this request for the treatment of opioid dependence? ☐ Yes ☐ No
3. Is this request for the treatment of pain? ☐ Yes ☐ No
4. Is the patient taking other opioids, tramadol, or carisoprodol? ☐ Yes ☐ No
5. Is the prescriber registered to prescribe Suboxone®/Subutex® under the Substance Abuse and Mental Health Services Administration (SAMHSA)? ☐ Yes ☐ No

Initiation of therapy or initial Medicaid review: (Supporting documentation is required for answers to all the questions)

1. Does the patient have a confirmed DSM-IV-TR diagnosis of opioid dependency? ☐ Yes ☐ No
2. Has an initial drug screen been performed to verify presence of opiates and other substances? ☐ Yes ☐ No
3. Has the patient failed more than one prior attempt with opiate agonist treatment within the past 12 months? ☐ Yes ☐ No
   If yes, provide date(s) of relapse(s): _____
4. Does the patient have co-morbid conditions that would interfere with compliance? ☐ Yes ☐ No
   List:
5. What best describes the recovery environment for this patient? ☐ Supportive ☐ Unsupportive ☐ Toxic
6. Has the patient been referred to a support group or licensed mental health counselor for psychological counseling? ☐ Yes ☐ No
   If yes, specify: _____
7. Has the patient been referred for a psychiatric evaluation if indicated? ☐ Yes ☐ No
8. Has the patient signed a contract (attach) and committed to both pharmacologic and non-pharmacologic modalities of treatment? ☐ Yes ☐ No
   Date of next office visit: _____

Continued on page 2. Both pages of the Suboxone®/Subutex® prior authorization form must be submitted for review.

Fax or mail completed forms to:
Magellan Complete Care
c/o Magellan Pharmacy Solutions
11013 West Broad Street, Suite 500
Glen Allen, VA 23060

Phone: 1-800-327-8613
TTY: 1-800-424-1694
Fax: 1-800-424-7982

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Recipient's Full Name

Continuation of therapy: (Supporting documentation is required for answers to all the questions)

1. Has the patient failed more than one prior attempt with opiate agonist treatment within the past 12 months? ☐Yes ☐No
   Drug screen (attach) date: _____
2. Is the patient compliant with non-pharmacologic therapy? ☐Yes ☐No
   Provide details (support type [group or individual], frequency of attendance, dates) _____
3. How long has the patient been stable at the current dose? _____
4. Is the patient ready to taper the dose at this time? ☐Yes ☐No
   If no, provide rationale: _____
   If yes, provide taper schedule: _____
5. Is the revised individualized treatment plan reflecting follow-up at the most current office visit attached for review? ☐Yes ☐No
   Date of next office visit: _____

Prior Authorization Standards for Review:

Medicaid prior authorization review is intended for office-based treatment of opioid dependency for individuals who meet the following criteria:

- With an adequate amount of psychosocial support; family/peers
- With a readiness for change and a personal commitment to live a drug-free lifestyle
- With a willingness to comply with all elements of the treatment plan, including pharmacologic and non-pharmacologic aspects of the established protocol
- With consistent regular drug screens that are negative for opiates
- With a willingness to abstain from illicit drugs

Helpful links:

Medicaid resources the SAMHSA recommendations http://www.samhsa.gov/

National Library of Medicine for *Clinical Guidelines for Use of Buprenorphine in the Treatment of Opioid Addiction*
http://www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=hssamhsatip&part=A72248

PRESCRIBER'S SIGNATURE: _____ **SAMHSA DEA#** _____

DATE: _____

REQUIRED FOR REVIEW: Copies of medical records (i.e., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs. **The provider must retain copies of all documentation for five years.**

Magellan Complete Care

MCC Physician Review: ☐ I do not recommend Approval. ☐ I recommend Approval for _____ months.

MCC Physician Signature: _____ **Date:** _____

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