Health Options
Highmark Blue Cross Blue Shield Delaware

Request for Prior Authorization Buprenorphine/Naloxone (Zubsolv, Suboxone) and Buprenorphine (Subutex)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

The purpose of this record is for payment purposes. The patient's medical record must substantiate the information provided on this form and compare for consistency. Medicaid reserves the right to request chart records to confirm the information provided below.

Providers are reminded of the Health Options general policy that prohibits cash billing for covered services.

Patients who require daily monitoring should be referred to a Medication Assisted Outpatient Treatment Program.

Prior Authorization Approval Conditions:

- **Induction: first 24-48 hours**
- **Stabilization Phase**
  - **Detox to drug free-** 52 units over 30 days
  - **Longer treatment-** Three doses a day for first week only.
- **Maintenance Phase (up to 24 months): Daily dosing limited to maximum 1 dose per day during maintenance phase.**
  - Prior authorization will be generated for the first 28 days, with approvals granted in increments of four 1 week supplies. Second requests can be approved for two months. Not to exceed a 30 day supply per dispensing. A third authorization for an additional 3 month approval with a maximum fill of 30 days may be requested.
  - Subsequent approvals for clients without issues will be granted for three additional 6 month authorizations. The third submission must contain plan of care to taper and transition off buprenorphine/naloxone. Request beyond 24 months will need to include a treatment plan along with evidence of socio-economic changes that substantiate significant success with treatment.
- Authorization requires a signed informed consent document related to opioid dependence therapy.
- Prior authorization can be cancelled at any point during therapy if a recipient fills a narcotic agent or other significant drug interaction regardless of the payer.
  - Urine screens that are positive for narcotics or benzodiazepines may result in immediate cancellation of coverage.
  - Rationale must be provided for minor or temporary interactions (such as low dose Benzodiazepine use, or <5 days of narcotic use).
  - Avoidance of these agents is recommended. Documentation of medical necessity is required.
- Clients who have failed three urine screens or relapsed three times will need to be referred to an ASAM defined Level I provider or a new medication option will be needed. Failures and relapses include:
  - Positive urine for illicit substances (including but not limited to cocaine, cannabis, heroin and street drugs), or prescription opioids.
  - Urine screening that indicates falsified drug screens (no norbuprenorphine) or other indicators that the client is not consuming the medication as directed.
  - Change in course of treatment defined as leaving one doctor to become a new start for another provider.
  - For any failure, a plan of care must be submitted that clearly indicates the change in treatment.

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Client name_____DOB: _____

Medicaid ID number:_____Substance of Abuse:_____

Practitioner name:_____NPI: _____XDEA: _____

Office phone number:_____Office fax number: _____

Medication name and strength:	Quantity:	Duration:
PMP reviewed for other controlled substances	Yes:_____ No: _____	Date Checked: _____
Status of treatment-Patient is considered renewal if previously treated by another physician.	New: _____ How long has patient been dependent on opioids? _____	Renewal: _____
Previous attempts at buprenorphine/naloxone treatment	Yes: _____ How many attempts: _____	No: _____
Counseling Regimen Name of practitioner:	Schedule per week:	Number of visits kept:_____ Number of visit missed or canceled:_____
Are there additional mental health diagnoses that are being treated?	Yes:	No:
Has patient been compliant with all schedules and had appropriate random urine drug screening results? (**Must attach quantitative laboratory results, instant UDS are not acceptable**):	Yes and results indicate appropriate drug use for both buprenorphine and other opioids: _____	No: _____
If buprenorphine is prescribed:	Client is pregnant- due date: _____	Other documentation of medical necessity is attached: Yes:_____ No: _____

This signature certifies that the information provided here is accurate and substantiated by the patient's medical records. The physician also certifies to tell Health Options of all relapses, breaks in treatment, inappropriate UDS, or patient discharges.

Physician Signature (required):_____

Date: _____

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DELAWARE HEALTH OPTIONS INFORMED CONSENT FORM FOR OPIOID DEPENDENCE TREATMENT

The purpose of this agreement is to give you information about the OPIOID DEPENDENCE medications you will be taking and to assure that you and your doctor/health care provider follow all state and federal regulations concerning the prescribing of controlled substances.

I have agreed to begin OPIOID DEPENDANCE TREATMENT. I understand that the purpose of this treatment is to keep me free of abusable-type drugs. This agreement is essential to ensuring I have a successful attempt at becoming drug free. By signing this document I acknowledge that:

1. I understand the medications used for treatment are still **controlled substances**. They are highly regulated by local, state, and federal authorities.
    a. I understand that it is a **felony to acquire these medications inappropriately without a prescription or to give or sell them to anyone**.
2. I will not request other controlled medication prescriptions from any other prescriber and by doing so I risk termination of treatment.
    a. I will inform my doctor of all medications I am taking, including anxiety medications, pain medications, cough syrups, and alcohol. Medications like these can interact with my medication and are not allowed during treatment.
    b. I acknowledge that mixing this medication with other controlled pain prescription medications, benzodiazepines, such as lorazepam (Ativan), diazepam (Valium), temazepam (Restoril), or clonazepam (Klonopin), tramadol, alcohol, or illicit drugs can be dangerous and is not allowed during treatment.
    c. I will not use any illegal substances, such as cocaine, marijuana, etc. while taking this medication. This may result in a change to my treatment plan, including safe discontinuation of my medications or complete termination of the doctor/patient relationship.
3. I agree to take the medication only as prescribed.
    a. I will not adjust the dose on my own and the eventual goal is to be titrated down in total daily dosage.
    b. I understand that increasing my dose or taking more than is prescribed without the close supervision of my doctor could lead to overdose and is considered misuse of medication.
    c. I take full responsibility to secure both the prescription and the medication safely so that they are not misplaced, lost, or misused by others. Lost or stolen medication will not be replaced.
4. I agree to participate in counseling while being treated.
    a. It is my responsibility to get all the information and any needed paperwork regarding my counseling I will provide adequate proof that I attended these sessions.
    b. I agree to be compliant with all my drug screens and drug counts.

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5. My pharmacy I will use will be: _____
    a. Located at: _____
    b. Telephone number: _____
6. I agree to try a different type of opioid treatment if I fail to follow this contract or fail to meet Health Options' requirement and still want to continue treatment.
7. I authorize my doctor and my pharmacy to fully cooperate with any city, state, or federal law enforcement agency, as well as the state in the investigation of any possible misuse, sale or diversion of medication. I authorized the doctor to provide a copy of this agreement to my pharmacy. I agree to waive any applicable right of privacy or confidentiality with respect to these authorizations.
8. I am aware of the side effects of taking my medication. This medication can produce side effects including, but not limited to, headache, insomnia, digestive issues, sweating, or weakness. Many of these the drugs used in opioid dependence treatment produce physical dependence of the opioid type, characterized by withdrawal signs and symptoms upon discontinuation or taper.
9. If I have used a drug before for opioid dependence treatment, I will let my current doctor know of my previous attempt(s) and will indicate the doctors seen previously here:

    _____

    _____
10. I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding this treatment have been adequately answered and a copy of this document has been given to me.

By signing this document, I acknowledge I have read the above information, that I will abide by all parts of it and that failure to do so may result in my medication being discontinued.

PATIENT PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

Revision Date: 11/06/14