BOSTON MEDICAL CENTER HealthNet Plan

ENVISION Rx OPTIONS

PRIOR AUTHORIZATION REQUEST FORM

BMCHP Buprenorphine Products MassHealth - Policy 9.153
Suboxone, Buprenorphine-naloxone, buprenorphine HCL, Bunavail, Zubsolv, Evzio
Phone: 888-566-0008 **Fax back to: 866-414-3453**

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please indicate which medication is being requested:

☐ Suboxone Sublingual Film
☐ Buprenoprhine-Naloxone Sublingual Tablets
☐ Buprenoprhine HCL Sublingual Tablets
☐ Bunavail
☐ Zubsolv sublingual tablets
☐ Evzio

Q2. Is the request for initial or continuing therapy? If continuing therapy, include the treatment start date.

☐ Initial
☐ Continuing / Start date (mm/yy):

Q3. Please indicate the diagnosis for which the requested medication is being prescribed, below:

☐ Primary treatment of opioid dependence
☐ Emergency treatment of known or suspected opioid overdose
☐ Other (please specify):

Q4. If the patient has a diagnosis of opioid dependence, is there active engagement or prior stabilization in a counseling program and remains so at this time?

☐ Yes ☐ No

This transmission may contain protected health information, which is transmitted pursuant to an authorization or as permitted by law. The information herein is confidential and intended only for use by the designated recipient who/which must maintain its confidentiality and security. If you are not the designated recipient, you are strictly prohibited from disclosing, copying, distributing, or taking action in reliance on the contents hereof. If you have received this transmission in error, please notify the sender immediately and arrange for the return or destruction of all of its contents. Unauthorized redisclosure of confidential health information is prohibited by state and federal law.

BOSTON MEDICAL CENTER HealthNet Plan

ENVISION Rx OPTIONS

PRIOR AUTHORIZATION REQUEST FORM

BMCHP Buprenorphine Products MassHealth - Policy 9.153
Suboxone, Buprenorphine-naloxone, buprenorphine HCL, Bunavail, Zubsolv, Evzio
Phone: 888-566-0008 Fax back to: 866-414-3453

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name: **Prescriber Name:**

Q5. Is there a consistent evaluation with toxicology screens? (If so, please indicate date)

☐ Yes (Date of last toxicology screen): ____________________
☐ No

Q6. Is the total daily dose being prescribed greater than 24 mg (buprenorphine component) per day? *

☐ Yes ☐ No

Q7. If YES, was there an inadequate response to 24 mg/day with dose titration within the previous three months?

☐ Yes ☐ No

Q8. If YES to Question 7, is the member at high risk of relapse if taking 24mg of buprenorphine daily?

☐ Yes ☐ No

Q9. If the request is for BUPRENORPHINE-NALOXONE SUBLINGUAL TABLETS, BUNAVAIL, or ZUBSOLV, is there an intolerance to a trial of the sublingual film formulation of Suboxone that is not expected to occur with the requested medication?

☐ Yes (specify reason for intolerance):____
☐ No

Q10. FOR BUPRENORPHINE HCL, is there an adverse reaction/contraindication to naloxone?

☐ Yes (describe adverse reaction/contraindication supported by medical records):____________________
☐ No

Q11. FOR EVZIO: Has the prescriber completed and submitted with this request the Opioid Overdose Risk Assessment Checklist Form? (available at http://evzio.com/pdfs/Evzio-Opioid-Overdose-Risk-Assessment-Checklist.pdf)

☐ Yes ☐ No

Q12. FOR EVZIO: Is the individual's care-giver is unable to provide a naloxone injection with the use of a prefilled syringe or vial due to issues related to a physical disability (such as poor eyesight, dexterity, etc.) or comprehension

☐ Yes ☐ No

Q13. Is the member currently pregnant? Provide the anticipated, documented date of delivery.

☐ Yes ☐ No

Q14. Is the member currently breastfeeding an infant <3 months of age with neonatal abstinence syndrome ?

☐ Yes (Please provide infant's age): ___________
☐ No

This transmission may contain protected health information, which is transmitted pursuant to an authorization or as permitted by law. The information herein is confidential and intended only for use by the designated recipient who/which must maintain its confidentiality and security. If you are not the designated recipient, you are strictly prohibited from disclosing, copying, distributing, or taking action in reliance on the contents hereof. If you have received this transmission in error, please notify the sender immediately and arrange for the return or destruction of all of its contents. Unauthorized redisclosure of confidential health information is prohibited by state and federal law.

BOSTON MEDICAL CENTER HealthNet Plan

ENVISION Rx OPTIONS

PRIOR AUTHORIZATION REQUEST FORM

BMCHP Buprenorphine Products MassHealth - Policy 9.153
Suboxone, Buprenorphine-naloxone, buprenorphine HCL, Bunavail, Zubsolv, Evzio
Phone: 888-566-0008 Fax back to: 866-414-3453

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name: **Prescriber Name:**

______________________________ ______________________________

Prescriber Signature Date

.

This transmission may contain protected health information, which is transmitted pursuant to an authorization or as permitted by law. The information herein is confidential and intended only for use by the designated recipient who/which must maintain its confidentiality and security. If you are not the designated recipient, you are strictly prohibited from disclosing, copying, distributing, or taking action in reliance on the contents hereof. If you have received this transmission in error, please notify the sender immediately and arrange for the return or destruction of all of its contents. Unauthorized redisclosure of confidential health information is prohibited by state and federal law.