Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Buprenorphine - Med Assisted Treatment

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans 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 (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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

Q1. Is the patient 16 years of age or older?

☐ Yes ☐ No

Q2. Has the patient been formally diagnosed with opioid use disorder according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria? (Please attach clinical information).

☐ Yes ☐ No

Q3. Is this request for a formulary buprenorphine product? *Please note, prescriptions for buprenorphine-naloxone tablet or buprenorphine tablet at a dose of 16 mg per day or less is available without prior authorization.

☐ Yes ☐ No

Q4. Is the requested medication injectable extended release buprenorphine?

☐ Yes ☐ No

Q5. Is the patient currently maintained on a buprenorphine product for at least 7 days (dose between 8 mg and 24 mg of buprenorphine equivalents) prior to initiation with buprenorphine injection?

☐ Yes ☐ No

Q6. Will injectable extended release buprenorphine be initiated at dosing in accordance with U.S. FDA approved labeling: 300 mg subcutaneously for the first 2 months followed by a maintenance dose of 100 mg monthly?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q7. Will the patient continue to receive supplemental doses of oral buprenorphine?

☐ Yes ☐ No

Q8. Has the patient had a previous therapeutic failure, contraindication, or intolerance to treatment with buprenorphine-naloxone or buprenorphine tablets? Documentation must be attached.

☐ Yes ☐ No

Q9. Is the dose being prescribed greater than 16 mg per day?

☐ Yes ☐ No

Q10. Is a treatment plan in place related to dose including a) clinical documentation supporting a buprenorphine dose greater than 16 mg per day, b) anticipated duration of treatment at this dose, c) and titration plan to reach maintenance dose of 16 mg per day. Documentation must be attached.

☐ Yes ☐ No

Q11. Is there documentation of referral to or participation in a substance abuse or behavioral health (BH) treatment program, BH counseling, or an addictions recovery program? During the initial course of treatment, referral and enrollment must be with a licensed Drug and Alcohol (D&A) or BH provider. Documentation including name, location, and counseling schedule or letter from behavioral health provider documenting participation must be attached.

☐ Yes ☐ No

Q12. Is the patient currently receiving methadone maintenance treatment?

☐ Yes ☐ No

Q13. Has the prescriber checked the patient's prescription history in the Prescription Drug Monitoring Program (PDMP)?

☐ Yes ☐ No

Q14. Requested Duration:

☐ 3 Months

Q15. Additional Information:

Prescriber Signature _____ Date _____

Updated 2018