Washington State Health Care Authority

COMMUNITY HEALTH PLAN of Washington™
The power of community

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and fax to **1-877-251-5896** as soon as possible to expedite this request. Without this information, your request may be denied.

Prior Authorization for Buprenorphine Monotherapy

Patient	Date of birth	ProviderOne ID

Physician name	Physician NPI	Physician's phone	Physician's fax

Pharmacy name	Pharmacy NPI	Pharmacy's phone	Pharmacy's fax

Medication name and strength	Directions for use	Quantity/days supply

Select from the following for your patient and complete associated question(s):

☐ Patient is pregnant. Estimated delivery date (EDD): _____

Was pregnancy confirmed with a lab test by the provider? ☐ Yes ☐ No

Is buprenorphine prescriber managing patient's pregnancy? ☐ Yes ☐ No

Has patient been stable on buprenorphine/naloxone for at least 8 weeks? ☐ Yes ☐ No

Patients approved based on pregnancy will be approved through 30 days after their EDD. When the client is no longer pregnant, transition to a buprenorphine/naloxone combination product is required for ongoing treatment unless client is breastfeeding.

☐ Patient is breastfeeding. Delivery date: _____

Patients approved based on breastfeeding, will be approved for 12 months following delivery. Transition to a buprenorphine/naloxone combination product is required for ongoing treatment thereafter.

☐ Patient has experienced a documented serious allergic or idiosyncratic reaction to the buprenorphine/naloxone combination product. **Chart notes documenting reaction are required.**

☐ Patient has continued to experience severe nausea or daily headache after trying at least two different formulations of buprenorphine/ naloxone combination products for at least 7 days each. Indicate formulations tried for at least 7 days (check all that apply):

☐ Buccal film ☐ Sublingual tab ☐ Sublingual film

Indicate the intended days supply per fill for your patient:

Best practice is to limit patients to a 7-day supply at a time.

☐ 7 days ☐ 14 days ☐ 28 days

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and fax to **1-877-251-5896** as soon as possible to expedite this request. Without this information, your request may be denied.

If over a 7 day supply is indicated:

- Is the reason due to transportation complications? ☐ Yes ☐ No
  If no, provide reason: _____
- Has patient demonstrated evidence of stability (8 weeks of treatment) taking buprenorphine monotherapy and/or buprenorphine/naloxone? ☐ Yes ☐ No
  If yes, how long has patient been clinically stable? _____

☐ I have read and understand Medication Treatment Guidelines for Substance Abuse Disorders (SUDs) – Buprenorphine Containing Products (www.hca.wa.gov/billers-providers-partners/programs-and- services/apple-health-medicaid-drug-coverage-criteria).

Prescriber signature	Prescriber specialty	Date

Notice Prohibiting Redisclosure of Alcohol or Drug Treatment Information

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.