UnitedHealthcare Community Plan

Medication Treatment for Substance Abuse Disorders (SUDs)
Request for Buprenorphine Monotherapy - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS

The following information below MUST be included upon submission:

□ Medication name, dose, duration □ All supporting labs and chart documentation

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

□ Patient is pregnant with an estimated delivery date (EDD):_____

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.

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

□ 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 (circle all that apply): Buccal film Sublingual tab Sublingual film

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

Indicate the intended days supply per fill for your patient: 7 day 14 day 28 day

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? _____

You must attach chart notes documenting a personally observed allergic reaction not attributable to withdrawal.

□ I have read and understand *Medication Treatment Guidelines for Substance Abuse Disorders (SUDs) – Buprenorphine Containing Products* (http://www.hca.wa.gov/billers-providers/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.