State of Maine Department of Health &Human Services
MaineCare/MEDEL Prior Authorization Form

BUPRENORPHINE – EXTENDED RELEASE

Phone: 1-888-445-0497 **www.mainecarepdl.org** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__|__| Patient Name: ______________________________ DOB: ________________
(NOT MEDICARE NUMBER)
Patient Address:____

Provider DEA: |__|__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|__|

Provider Name:____ Phone:__________________

Provider Address:____ Fax:__________________

Pharmacy Name:_________________________Rx Address:___________________________Rx phone:_______________

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

Preferred cost-effective options include Suboxone films and oral tablets of buprenorphine/naloxone. However, some members may qualify for extended-release buprenorphine.

Drug Name	Strength	Dosage Instructions	Quantity	Days Supply (34 retail / 90 mail order)	Refills
________________________	_________	__________	_________	____________	1 2 3 4 5

Medical Necessity Documentation Required: (Attach copies of supporting office notes.)

The prescriber can attest (and medical record should document) that:

- ❑ member has a documented history of opioid use disorder (OUD),
- ❑ XRB is being used for the treatment of OUD (rather than pain or any other non-FDA approved indication) and
- ❑ member's total daily dose of sublingual buprenorphine is less than or equal to 24 mg daily.

AND at least one of the following is true:

- ❑ The member's previous use of sublingual buprenorphine has included misuse, overuse, or diversion.
- ❑ The member is at high risk of overdose (e.g., individuals leaving incarceration or abstinence-based treatment programs; individuals who are unhoused; or those facing potential gaps in care due to delays in care or geographically limited treatment access).
- ❑ The member has difficulty keeping OUD treatment medications safe (e.g., because they are unhoused or living in unstable settings)
- ❑ The member has experienced significant medical complications of OUD and/or of injection drug use. Occurrence should be in the last 5 years, or it should be clearly documented that the risk indicated by this infection or complication is ongoing
    - *(Examples of medical complications of OUD include: threatened the function of organs or life or limb threatening and required medical and/or surgical therapy. Examples of medical complications of injection drug use include osteomyelitis, endocarditis, renal failure, joint infection or other serious medical complications directly related to OUD.)*

- ❑ The member has treatment-resistant OUD, including those with ongoing illicit substance use in the context of sublingual buprenorphine treatment as documented by positive urine drug screens or other clear objective evidence, and/or further functional decline with explicit documentation of the functional decline.

- ❑ The member has a significant intolerance of, or documented allergy to, sublingual buprenorphine (either buprenorphine monotherapy or buprenorphine/naloxone combination therapy) that has resulted in the patient's inability to comply with continued treatment using the sublingual product.
    - *(A true allergy is usually accompanied by rash, respiratory symptoms, or anaphylaxis. Other complaints such as bad taste, mouth tingling, etc. do not constitute evidence of allergy or significant intolerance. Formulation preference or convenience are not, in and of themselves, indications for using XRB.)*

- ❑ The member is in ongoing treatment with XRB and would like to continue the medication.

Certification to seek exception from chart documentation requirement:
I certify that (a) the information provided is accurate and complete to the best of my knowledge, and (b) that any required supporting medical record documentation is physically or electronically accessible and satisfies the explicitly posted relevant PDL criteria. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. As per MaineCare Benefits Manual, Chapter I, Sections 1.16 and 1.19, "sanctions" (including recouping payments previously made) "may be imposed by the Department against a provider submitting false information for the purpose of meeting prior authorization requirements."

Provider Signature: ____ Date of Submission: ________________________________
***MUST MATCH PROVIDER LISTED ABOVE**