

Service Authorization (SA) Form  
ORAL BUPRENORPHINE PRODUCTS

**Preferred Suboxone® SL film in dosages 24 mg/day or less prescribed by any in-network, buprenorphine-waivered provider does not require a SA.**

Length of Authorization: 3 Months (Initial SA), 6 months (Maintenance SA)

If the following information is not complete, correct, and legible, the SA process could be delayed.

Please use one form per member.

**MEMBER INFORMATION**

Last Name:

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First Name:

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Medicaid ID Number:

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Date of Birth:

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Gender:  Male  Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Last Name:

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First Name:

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NPI Number:

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Specialty:

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Phone Number:

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Fax Number:

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DEA X #:

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DEA X # Expiration:

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**DRUG INFORMATION**

**OPIOID DEPENDENCY – ORAL BUPRENORPHINE**

The Board of Medicine reg 18VAC85-21-150: DOSES GREATER THAN 24 MG/DAY WILL DENY.

**Maximum Quantities for Dose Optimization (Preferred Drugs)**

- |   |  |
|---|--|
| <input type="checkbox"/> buprenorphine SL tab 2 mg; 3/day     | <input type="checkbox"/> buprenorphine SL tab 8 mg; 2/day    |
| <input type="checkbox"/> Suboxone® SL film 2 mg/0.5 mg; 3/day | <input type="checkbox"/> Suboxone® SL film 4 mg/1 mg; 1/day  |
| <input type="checkbox"/> Suboxone® SL film 8 mg/2 mg; 3/day   | <input type="checkbox"/> Suboxone® SL film 12 mg/3 mg; 2/day |

**Maximum Quantities for Dose Optimization (Non-Preferred Drugs)**

- |  |   |
|--|---|
| <input type="checkbox"/> Bunavail™ 2.1 mg/0.3 mg buccal film; 1/day        | <input type="checkbox"/> Bunavail™ 4.2 mg/0.7 mg buccal film; 2/day       |
| <input type="checkbox"/> Bunavail™ 6.3 mg/1 mg buccal film; 3/day          | <input type="checkbox"/> buprenorphine/naloxone SL tab 2 mg/0.5 mg; 3/day |
| <input type="checkbox"/> buprenorphine/naloxone SL film 2 mg/0.5 mg; 3/day | <input type="checkbox"/> buprenorphine/naloxone SL film 4 mg/1 mg; 1/day  |
| <input type="checkbox"/> buprenorphine/naloxone SL film 8 mg/2 mg; 3/day   | <input type="checkbox"/> buprenorphine/naloxone SL tab 8 mg/2 mg; 3/day   |
| <input type="checkbox"/> Zubsolv™ SL tab 0.7 mg/0.18 mg; 2/day             | <input type="checkbox"/> Zubsolv™ SL tab 1.4 mg/0.36 mg; 2/day            |
| <input type="checkbox"/> Zubsolv™ SL tab 2.9 mg/0.71 mg; 2/day             | <input type="checkbox"/> Zubsolv™ SL tab 5.7 mg/1.4 mg; 2/day             |
| <input type="checkbox"/> Zubsolv™ SL tab 8.6 mg/2.1 mg; 2/day              | <input type="checkbox"/> Zubsolv™ SL tab 11.4 mg/2.9 mg; 2/day            |

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

**TREATMENT INFORMATION**

**SA Criteria Align with Virginia Board of Medicine's Regulations Governing Prescribing of Opioids and Buprenorphine**

1. Member's pregnancy has been confirmed by a positive laboratory test.

Yes     No

Buprenorphine mono-product will only be covered for pregnant women for a maximum of 10 months.  
Document expected date of delivery: \_\_\_\_\_

(IF YES, PLEASE SIGN AND SUBMIT, NO FURTHER INFORMATION REQUIRED unless a non-preferred/non-formulary drug is prescribed. See Q8 if non-formulary drug is prescribed.)

2. Member meets criteria for a diagnosis of Opioid Use Disorder

(defined by DSM 5: <https://pcssnow.org/resource/opioid-use-disorder-opioid-addiction/>).

Yes     No

3. Member is 16 years of age or older.

Yes     No

**VIRGINIA PRESCRIPTION MONITORING PROGRAM (PMP)**

<https://www.dhp.virginia.gov/PractitionerResources/PrescriptionMonitoringProgram/>

Prescriber has reviewed the Virginia Prescription Monitoring Program (PMP) before the initiation of therapy.

Yes     No

4. The prescriber has reviewed the Virginia PMP **on the date of the request for maintenance** of therapy.

Yes     No

**CONCURRENT MEDICATIONS**

5. Due to a higher risk of fatal overdose with concomitant use of benzodiazepines, opioids, sedative hypnotics, tramadol, and carisoprodol, the prescriber shall only co-prescribe these drugs when there are extenuating circumstances and shall document in the medical record a tapering plan to achieve the lowest possible effective doses of these medication. Prescriber has a documented tapering plan.

Yes     No

*(Form continued on next page.)*

Member's Last Name:

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Member's First Name:

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**URINE DRUG SCREENING DURING THE MAINTENANCE PHASE**

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6. Prescriber is checking random urine drug screens as part of the treatment plan. (The urine drug screens should check for buprenorphine, norbuprenorphine, methadone, oxycodone, benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates.)  
 Yes     No

7. **Non-Preferred agents** require documentation as to why the member cannot be prescribed a preferred agent. Include details. *A completed FDA [MedWatch Form](#) is required to be attached for adverse reactions to combination products.*

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**Prescriber Signature (Required)**

**Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; incomplete forms will delay the SA process.**

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be faxed to **1-800-922-3986**, phoned to **1-800-424-4524 (TTY 711)** or mailed to:

**Magellan Rx Management Prior Authorization Program**  
**c/o Magellan Health, Inc.**  
**11013 West Broad Street**  
**Glen Allen, VA 23060**