MAGELLAN COMPLETE CARE OF VIRGINIA – CCC PLUS

Service Authorization (SA) Form

Extended Release Buprenorphine (Sublocade™)

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member. **Initial SA** requests for maintenance therapy may be approved for 3 months. **Subsequent requests** may be approved for up to 6 months.

Criteria align with Virginia Board of Medicine's Regulations Governing Prescribing of Opioids and Buprenorphine.

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

MCC VA ID Number:

Date of Birth: ☐☐ – ☐☐ – ☐☐☐☐

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Specialty:

Phone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

Fax Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

DEA X #: ☐☐ – ☐☐☐☐☐☐☐

DEA X # EXP: ☐☐ – ☐☐☐☐☐☐☐

PHARMACY INFORMATION *(if available)*

Pharmacy Name:

Phone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

Fax Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

(Form continued on next page.)

 Revision Date: 07/10/2018

Member's Last Name:

Member's First Name:

TREATMENT INFORMATION

1. Does member meet criteria for a diagnosis of **Opioid Use Disorder** defined by DSM 5: (http://pcssnow.org/wp-content/uploads/2014/02/5B-DSM-5-Opioid-Use-Disorder-Diagnostic-Criteria.pdf)?
   ☐ Yes ☐ No
2. Is the member 16 years of age or older?
   ☐ Yes ☐ No
3. Has the member initiated treatment with a transmucosal buprenorphine-containing product followed by dose adjustment for a minimum of seven days?
   ☐ Yes ☐ No
4. Will Sublocade™ dosing be in accordance with the U.S. Food and Drug Administration approved labeling: 300 mg subcutaneously monthly for the first 2 months, followed by a maintenance dose of 100 mg monthly? (**Note:** Increasing the maintenance dose to 300 mg monthly may be considered for patients for whom the benefits outweigh the risks.)
   ☐ Yes ☐ No
5. Because of the risk of serious harm or death that could result from intravenous self- administration, Sublocade™ is only available through a restricted program called the **Sublocade™ REMS Program**. Health care settings and pharmacies that order and dispense Sublocade™ must be certified in this program and comply with the REMS requirements. Will the prescriber follow are the terms and conditions of the Sublocade™ REMS Program? (**Note:** For more information visit https://www.sublocaderems.com/.)
   ☐ Yes ☐ No

PSYCHOLOGICAL COUNSELING

6. For **Initial treatment** (first 3 months): Is the member participating in psychosocial counseling (individual or group) at least once per week?
   ☐ Yes ☐ No
7. For **Maintenance** (after the first 3 months): Is the member participating in psychosocial counseling (individual or group) at least once to twice per month?
   ☐ Yes ☐ No

Provide information of **health care provider** providing counseling and date of next appointment: _____

Behavioral Health Provider's Last Name:

Behavioral Health Provider's First Name:

Phone Number: ___ – ___ ____

Fax Number: ___ – ___ – ____

Note: Magellan Rx Management may review claims data to confirm that the member is receiving counseling. If the provider is not billing for counseling, provide the most recent counseling note.

Member's Last Name:

Member's First Name:

VIRGINIA PRESCRIPTION MONITORING PROGRAM (PMP)

Virginia PMP Login website: https://virginia.pmpaware.net/login

8. Has the prescriber reviewed the Virginia PMP **before the initiation of therapy**?

   ☐ Yes ☐ No Fill date of last opioid Rx: _____

   Fill date of last benzodiazepine Rx: _____

9. Has the prescriber reviewed the Virginia PMP **on the date of the request for Maintenance of therapy**?

   ☐ Yes ☐ No

CONCURRENT MEDICATIONS

10. Is the member taking any of these medications: benzodiazepines, opioids, sedative hypnotics, tramadol (Ultram), carisoprodol (Soma)?

    ☐ Yes ☐ No

11. Due to a higher risk of fatal overdose with concomitant use of these drugs, the prescriber shall only co-prescribe these substances 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. Does the prescriber have a documented tapering plan?

    ☐ Yes ☐ No

URINE DRUG SCREENING DURING THE MAINTENANCE PHASE

12. Is the prescriber checking random urine drug screens at least **4 times per 6 months**?

    ☐ Yes ☐ No

    NOTE: The urine drug screens **MUST** check for buprenorphine, norbuprenorphine, methadone, oxycodone, benzodiazepines, amphetamine/methamphetamine, cocaine, heroin, THC, and other prescription opiates.

13. The prescriber has provided the **last 2 urine drug screens (with at least 1 of these screenings within past month)**?

    ☐ Yes ☐ No

14. Are all urine drug screens positive for buprenorphine/norbuprenorphine?

    ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name:

Member's First Name:

15. Are all urine drug screens negative for all other substances?

☐ Yes ☐ No

NOTE: If a drug screen is negative for buprenorphine/norbuprenorphine and positive for another substance, provide written documentation of steps being taken to address member's possible diversion of buprenorphine and/or ongoing use of other substances including intensifying the counseling that member is receiving and/or considering referral to higher level of care (such as intensive outpatient, partial hospitalization, or residential treatment).

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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 Magellan Complete Care of Virginia.

The completed form may be **FAXED TO 1-800-922-3986** or mailed to:

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

Phone: 1-800-424-4524 (TTY 711)

