Magellan COMPLETE CARE®

MAGELLAN COMPLETE CARE OF VIRGINIA – MEDALLION 4.0

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:

First Name:

Medicaid 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 # Expiration: ☐☐ – ☐☐ – ☐☐☐☐

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)

- ☐ buprenorphine SL tab 2 mg; 3/day
- ☐ Suboxone® SL film 2 mg/0.5 mg; 3/day
- ☐ Suboxone® SL film 8 mg/2 mg; 3/day
- ☐ buprenorphine SL tab 8 mg; 2/day
- ☐ Suboxone® SL film 4 mg/1 mg; 1/day
- ☐ Suboxone® SL film 12 mg/3 mg; 2/day

Maximum Quantities for Dose Optimization (Non-Preferred Drugs)

- ☐ Bunavail™ 2.1 mg/0.3 mg buccal film; 1/day
- ☐ Bunavail™ 6.3 mg/1 mg buccal film; 3/day
- ☐ buprenorphine/naloxone SL film 2 mg/0.5 mg; 3/day
- ☐ buprenorphine/naloxone SL film 8 mg/2 mg; 3/day
- ☐ Zubsolv™ SL tab 0.7 mg/0.18 mg; 2/day
- ☐ Zubsolv™ SL tab 2.9 mg/0.71 mg; 2/day
- ☐ Zubsolv™ SL tab 8.6 mg/2.1 mg; 2/day
- ☐ Bunavail™ 4.2 mg/0.7 mg buccal film; 2/day
- ☐ buprenorphine/naloxone SL tab 2 mg/0.5 mg; 3/day
- ☐ buprenorphine/naloxone SL film 4 mg/1 mg; 1/day
- ☐ buprenorphine/naloxone SL tab 8 mg/2 mg; 3/day
- ☐ Zubsolv™ SL tab 1.4 mg/0.36 mg; 2/day
- ☐ Zubsolv™ SL tab 5.7 mg/1.4 mg; 2/day
- ☐ Zubsolv™ SL tab 11.4 mg/2.9 mg; 2/day

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

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:

Member's First Name:

URINE DRUG SCREENING DURING THE MAINTENANCE PHASE

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.*

   _____

   _____

Prescriber Signature (Required)
By signature, the physician confirms the above information is accurate and verifiable by member records.

Date

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 **800-424-7581**, phoned to **800-424-4518 (TTY 711)**, or mailed to:

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