

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:

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Member’s First Name:

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MCC VA 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 # EXP:

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**PHARMACY INFORMATION (if available)**

Pharmacy Name:

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Phone Number:

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Fax Number:

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(Form continued on next page.)

**Member's Last Name:**

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**Member's First Name:**

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**TREATMENT INFORMATION**

- 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
- Is the member 16 years of age or older?  
 Yes     No
- Has the member initiated treatment with a transmucosal buprenorphine-containing product followed by dose adjustment for a minimum of seven days?  
 Yes     No
- 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
- 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**

- For **Initial treatment** (first 3 months): Is the member participating in psychosocial counseling (individual or group) at least once per week?  
 Yes     No
- 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:**

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**Behavioral Health Provider's First Name:**

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**Phone Number:**

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**Fax Number:**

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**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:

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Member's First Name:

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**VIRGINIA PRESCRIPTION MONITORING PROGRAM (PMP)**

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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**

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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**

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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:

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Member's First Name:

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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 1-800-424-7581** or mailed to:

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

**Phone:** 1-800-424-4518 (TTY 711)