

**Oral Buprenorphine Products Do not require a PA if:**

- It is for a preferred product Suboxone® SL film or buprenorphine/naloxone tablets;
- The member must be 16 years of age or older
- The prescribed dose must be less than or equal to 24 mg/day

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

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

Please use one form per member.

**MEMBER INFORMATION**

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Specialty:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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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**DRUG INFORMATION**

**OPIOID DEPENDENCY – ORAL BUPRENORPHINE**

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

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

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

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

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

- buprenorphine/naloxone SL film 2 mg/0.5 mg; 3/day
- buprenorphine/naloxone SL film 4 mg/1 mg; 1/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
- buprenorphine/naloxone SL film 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

**TREATMENT INFORMATION**

PA Criteria align with Virginia Board of Medicine's Regulations Governing Prescribing of Opioids and Buprenorphine: <http://www.dhp.virginia.gov/medicine/>

- Your 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 Q12 if non-formulary drug is prescribed.)

- Does member meet criteria for a diagnosis of Opioid Use Disorder (defined by DSM 5: <https://pcssnow.org/resource/opioid-use-disorder-opioid-addiction/>)?  
 Yes     No
- Is the member 16 years of age or older?  
 Yes     No

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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4. **Non-Preferred agents** require documentation as to why the member cannot be prescribed a preferred agent. Include details and a **completed FDA MedWatch Form** (<https://www.accessdata.fda.gov/scripts/medwatch/index.cfm>) 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.