Neighborhood Health Plan OF RHODE ISLAND™

Sublocade Authorization form
Q9991, Q9992

Tel. 401-427-8200; Fax 844-639-7906

Sublocade (buprenorphine extended release) Prior Authorization form (Drugs Administered in Office), fax requests to 844-639-7906

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
Member Phone Number:	Member Address:	Gender: □ Male □Female □Unknown Primary Language: □ English □Spanish □ Other:
REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Date of Request:	Provider's NPI #:	Provider's Contact Name and Phone:

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

❑ Drop Ship from Specialty Pharmacy: _____and NPI_____

❑ If Buy & Bill: Specify Provider/ Facility: _____ and NPI _____

Servicing Provider Fax#: _____

CLINICAL INFORMATION		
Requested J-Code:	Requested CPT code(s):	□ Initial Request □ Continuation of therapy Request
Drug Name& strength:		Date(s) of Service Requested:
Directions:		# of units:
ICD 10 Codes:		

Clinical Assessment (provide all required information and clinical documentation)	YES	NO
Is the patient at least 18 years of age?	☐	☐
Does the patient have a diagnosis of moderate to severe opioid use disorder?	☐	☐
Has the member initiated therapy with transmucosal buprenorphine containing product (delivering the equivalent of 8-24mg of buprenorphine daily) over a minimum of 7 day period and is stable with clinically controlled cravings and withdrawal symptoms?	☐	☐
Is the member part of a complete treatment program that includes counseling and psychosocial support?	☐	☐
Is the member receiving opioids during therapy with Sublocade (buprenorphine extended release)?	☐	☐
Has the prescriber provided rationale and medical documentation to support the member's inability to continue to use oral formulations of buprenorphine (such as failed treatment history with oral formulations, lack of adherence or patients at high risk of treatment failure due to other comorbidities)?	☐	☐
Does the dose exceed 300mg a month?	☐	☐

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Continuation of therapy:		
Does the member meet all initial approval criteria AND is tolerating Sublocade?	☐	☐
Does the member shown signs of opioid dependence-relapse?	☐	☐
NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN		
Signature of Requesting Provider:	**Date:**	

Authorization is not a guarantee of payment. Member must be eligible at time of service.

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