A close-up of a logo

Description automatically generated**Montana Healthcare Programs Prior Authorization Request form for use of Brixadi**® **(buprenorphine extended-release)**

|  |  |  |
| --- | --- | --- |
| Member Name: | Medicaid ID: | DOB: |
| Provider Name: | Provider Phone: | Provider Fax: |
| Dose/regimen requested: | | |

***Please complete below information for applicable situation, Initiation or Continuation of therapy:***

* **INITIATION OF THERAPY**

**Weekly Brixadi**®

1. Member is 18 years of age or older: **£** Yes **£** No
2. Provider is a Montana Healthcare Programs enrolled provider: **£** Yes **£** No
3. Assessment/screening supports a diagnosis of Opioid Use Disorder (DSM-V): **£** Yes **£** No
4. Provide clinical rationale documenting the necessity to switch to an injectable product:

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1. Provider has performed an overdose risk assessment and recommended naloxone, if appropriate: **£** Yes **£** No
2. Provider attests to the following:

Member **NOT currently receiving** buprenorphine treatment:

**** Has tolerated at least one sublingual 4mg dose of buprenorphine prior to injection AND

* + Will NOT receive injection in the **upper arm** until steady state has been achieved (4 consecutive doses). Buttock, thigh, or abdomen are the appropriate sites of injection for those not previously maintained on buprenorphine until steady state.

Member **currently receiving** buprenorphine treatment:

* + Will be transitioned from another buprenorphine product according to the labeling.

**Limitations:** Maximum dose: 32mg every 7 days.

**Initial authorization will be granted for 6 months.**

***Note: Initial 3 months of therapy will be approved on a monthly basis to reduce risk of waste. After initial 3 months of therapy is complete, prior authorization will be put in for the remaining 3 months of therapy.***

**Monthly Brixadi**®

1. Member is 18 years of age or older: **£** Yes **£** No
2. Provider is a Montana Healthcare Programs enrolled provider: **£** Yes **£** No
3. Assessment/screening supports a diagnosis of Opioid Use Disorder (DSM-V): **£** Yes **£** No
4. Provide clinical rationale documenting the necessity to switch to an injectable product:

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1. Provider has performed an overdose risk assessment and recommended naloxone, if appropriate: **£** Yes **£** No
2. Provider attests to the following:
   * Member is currently being treated with a transmucosal buprenorphine-containing product of at least 8mg per day OR
   * Member is currently transitioning from Brixadi® weekly of at least a dose of 16mg per week.

**Limitations:** Maximum dose: 128mg every 28 days.

**Initial authorization will be issued for 6 months.**

***Note: Initial 3 months of therapy will be approved on a monthly basis to reduce risk of waste. After initial 3 months of therapy is complete, prior authorization will be put in for the remaining 3 months of therapy.***

* **CONTINUATION OF THERAPY**

1. Member has documentation of positive clinical response to therapy: **£** Yes **£** No
2. Provider is a Montana Healthcare Programs enrolled provider: **£** Yes **£** No

**Limitations:**

* + Maximum dose for weekly therapy: 32mg every 7 days.
  + Maximum dose for monthly therapy: 128mg every 28 days.

**Renewal authorization will be issued for 12 months.**

**Please complete the form and fax it to the Montana Healthcare Program’s Drug Prior Authorization Unit at 1-800-294-1350**

4/2024