CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

CareFirst Community Health Plan District of Columbia

ABARCA

SUBOXONE (buprenorphine/naloxone)
Prior Authorization Request Form (Dosages > 24/6 mg)

Phone: 1-866-287-6156 | Fax: 1-866-839-2372 | www.carefirstchpdc.com
Monday – Friday: 8:00 AM to 4:30 PM

Coverage Policy: Coverage for the treatment of opioid dependence will be provided when ALL of the following conditions are met:

- Diagnosis of opioid dependence **AND**
- Verification from prescriber that he/she meets all of the qualification criteria to prescribe Suboxone **AND**
- Active participation of enrollee in a formal substance abuse counseling or treatment program; OR verification that prescriber (if a psychiatrist or certified addiction specialist) personally renders treatment or counseling services **AND**
- Documentation of a minimum of two performed toxicology screenings annually to evaluate and monitor any ongoing substance use for enrollee receiving treatment

****All fields must be complete and legible for review****
Prior authorizations cannot be completed over the phone.

Enrollee Information		**Provider Information**	
Enrollee Name:		**Provider Name:**	
Enrollee ID#:	**Date of Birth:**	**NPI:**	**Specialty:**
Phone:		**Phone:**	**Fax:**
Address:		**Facility/Clinic Name:** **Address:**	
Drug Allergies:		**Pharmacy Name:**	**Pharmacy Phone:** **Pharmacy Fax:**

General Information				
Requested Drug: ☐ **Buprenorphine/naloxone** ☐ **Suboxone (Brand)**	**Strength/ Formulation:** _____ mg	☐ **Sublingual film** ☐ **Sublingual tablet** ☐ **Buccal film**	**Quantity:**	**Day Supply:**	**Dosing Frequency:**

The following criteria must be met for the request to be considered complete (*Please check boxes*)**:**

☐ Prescription Drug Monitoring Program (PDMP) reviewed ☐ Naloxone nasal spray prescribed/provided

Clinical Information	
ICD-10 Codes(s):	**Is enrollee currently pregnant?** [*For females, ages 16-45*] ☐ **NO** ☐**YES** *(If yes, please complete pregnancy section on last page)*
Diagnosis:	**Is enrollee currently taking other sedating medications?** ☐ **NO** ☐**YES** (*e.g. benzodiazepines, sedatives/hypnotics, muscle relaxants, other opioids*) **Medication:** _____ **Diagnosis / ICD-10 code:** _____

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MURIEL BOWSER, MAYOR
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Initial Requests (*Approval for 12 months*)	
Please check all applicable criteria: ☐ **Enrollee is ≥ 16 years old** ☐ **There are no untreated/unstable psychiatric conditions that would interfere with Suboxone® adherence** ☐ **Risks of using Suboxone with alcohol or benzodiazepines has been discussed with enrollee** ☐ **Enrollee has been referred to or is currently participating in formal counseling or psychosocial treatment with a licensed behavioral health provider**	**Mental Health Substance Abuse Counseling:** **Counselor Name:** _____ **Facility Name:** _____ *(Please contact CareFirst CHPDC's behavioral health department at 202-821-1100 for assistance with finding a provider in network)*

Renewal Requests (*Approval for 12 months)*	
Please check all applicable criteria: ☐ **Consistent use of Suboxone® since previous authorization** *(will be verified via claims data)* ☐ **Ongoing behavioral health care for co-existing behavioral health disorders** *(if applicable)* ☐ **Enrollee is currently participating in formal counseling or psychosocial treatment with a licensed behavioral health provider and adherent with sessions**	**Mental Health Substance Abuse Counseling:** **Counselor Name:** _____ **Facility Name:** _____

Additional Information Please provide any additional pertinent information to support the requested use of Suboxone above the FDA-approved dosing limit.

Completed By: _____ Date: _____

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Pregnant Enrollees (*Only complete for pregnant or nursing women*)	
Is the member pregnant?	☐ **YES** ☐ **NO**
Is the member nursing?	☐ **YES** ☐ **NO**
Has the prescribing physician discussed with the member that methadone maintenance is the standard of care for opioid addiction treatment in pregnant women?	☐ **YES** ☐ **NO**
Has the prescribing physician informed the member about the limited safety data for the support of buprenorphine use in pregnant or nursing women?	☐ **YES** ☐ **NO**

Physician Signature: _____ **Date Signed:** _____

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