CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 2000**3**
www.carefirstchpdc.com

CareFirst Community Health Plan District of Columbia

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SUBOXONE (buprenorphine/naloxone)
Enrollee Buprenorphine Treatment Contract

Patient Name: _____ Date: _____

As a participant in the buprenorphine treatment for opioid misuse and dependence, I freely agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my schedule appointments.
2. I agree to adhere to the rules and responsibilities outlined by my doctor.
3. I agree to conduct myself in a courteous manner with my doctor, within my doctor's office, and with CareFirst Community Health Plan, District of Columbia (CHPDC) employees.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and could result in my treatment being terminated without any recourse to appeal.
5. I agree that the medication/prescription can only be given to me at a regular office visit. A missed visit may result in me not being able to get my medication/prescription until the next scheduled visit.
6. I agree that the medication I receive is my responsibility and I agree to keep it in a safe secure place. I agree that lost medication will not be replaced regardless of why it was lost.
7. I agree not to obtain any opiate medications from other doctors, pharmacies, or other sources without telling my buprenorphine treatment doctor first.
8. I understand that mixing buprenorphine with other medications, especially benzodiazepines *(ex. diazepam, clonazepam, alprazolam, etc),* can be dangerous and will only do so with the consent of my doctor. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines *(especially if taken outside of the care of a doctor, using routes of administration other than the sublingual route or in higher than recommended therapeutic doses)*.
9. I agree to take my medication as my doctor instructed and not alter the way I take my medication without first consulting my doctor.
10. I understand that medication alone is not sufficient treatment for my condition and I agree to participate in counseling or group therapy as discussed and agreed upon with my doctor and specified in my treatment plan. I agree to provide CareFirst CHPDC proof of my attendance to the counseling meetings upon request.
11. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances *(excepting nicotine).*
12. I agree to provide random urine samples for urine drug screening if asked and have my doctor test my blood alcohol level. I understand that positive urines could result in no further authorization for buprenorphine.
13. I understand that violations of the statements listed above may be grounds for termination of treatment.

Enrollee Signature: _____ Date: _____

Enrollee Name Printed: _____

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

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
- *Requests for coverage beyond 12 months of treatment are subject to the health plan's review for consideration of further approval*

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

Patient Information	Provider Information
Patient Name:	**Provider Name:**
Member ID#:	**NPI:**
Date of Birth:	**Specialty:**
Phone:	**Office Phone: ( )**
Address:	**Office Fax: ( )**
	Office Street Address:
Drug Allergies:	

General Information

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

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

- ☐ Provided copy of most recent urine drug screen for opiates (***required***) *Date*: _____
- ☐ Signed Enrollee Buprenorphine Agreement Form
- ☐ Prescription Drug Monitoring Program (PDMP) checked

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Clinical Information

Diagnosis:	**ICD-10 Codes(s):**
[*For females, Ages 16-45*] **Is enrollee currently pregnant?** *(If yes, complete pregnancy section on last page)* ☐ **NO** ☐ **YES**	**Has pharmacogenetic testing been conducted to detect CYP3A4 allelic variation?** *(Attach documentation)* ☐ **NO** ☐ **YES**

Is enrollee currently taking other sedating medications?	**List other sedating agents enrollee is currently taking** (*e.g. benzodiazepines, sedatives/hypnotics, muscle relaxants, other opioids*)	
☐ **NO**	**Medications:**	**Diagnosis / ICD-10 code:**
☐ **YES**	_____	_____
	_____	_____

Initial Requests (*Approval for 3 months*)

Please check all applicable criteria:
(please attach clinical progress note)

☐ **Enrollee is ≥ 16 years old**

☐ **There are no untreated/unstable psychiatric conditions that would interfere with Suboxone® compliance**

☐ **Risks of using Suboxone with alcohol or benzodiazepines has been discussed with enrollee**

☐ **Enrollee has been referred to or is currently receiving formal counseling with a licensed behavioral health provider**

☐ **Documentation of regular urine tests (every 1-2 months) for opiates** *(please attach)*

Test results for urine drug screen

☐ **Negative** ☐ **Positive**

Has enrollee's withdrawal symptoms been assessed using a Clinical Subjective/Objective Withdrawal Scale
(attach documentation)

☐ **YES** **OOWS / COWS / SOWS**

☐ **NO** **Score: _____**

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)

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Renewal Requests (*ONLY for renewals*)

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 with a licensed behavioral health provider and compliant with sessions**

☐ **Documentation of regular urine tests (every 1-2 months) for opiates** *(please attach)*

Test results for urine drug screen

☐ **Negative** ☐ **Positive**

Mental Health Substance Abuse Counseling:

Counselor Name: _____

Facility Name: _____

Date of last session: _____

Will a tapering plan be considered at this time?

☐ **Yes** ☐ **No**

Positive Urine Drug Screen:
Please describe what steps are being taken to address the positive urine drug screen for illicit opiates:

_____

_____

Additional Information

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

(ex. Genetic lab test results, use of CYP3A4 inducers, screening assessments)

_____

_____

_____

Completed By: _____ Date: _____

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☐	**The enrollee has agreed that information about his/her treatment with Suboxone can be shared between his/her PH and BH MCO's and with his/her Primary Care and Behavioral Providers in order to better coordinate the services needed to successfully treat his/her substance abuse condition. I attest that a copy of the necessary specific written consent is filed in the patient's medical record.**

Physician Signature: _____ Date Signed: _____

Attestation

The U.S Department of Health and Human Services endorse the Federation of State Medical Boards-Model Policy Guidelines for Opioid Addictions Treatment. The prescribing physician agrees to follow these guidelines, including:

- The patient should receive opioids from only one physician and one pharmacy when possible
- The physician should employ the use of a written agreement between the physician and patient addressing issues such as:
  - Alternative treatment options
  - Regular toxicology testing for drugs of abuse and therapeutic drug levels
  - Number and frequency of all prescription refills
  - Reason for which drug therapy may be discontinued
- Continuation or medication of opioid therapy should depend on the physician evaluation of progress toward state treatment objectives such as
  - Absence of toxicity
  - Absence of medical or behavioral adverse effects
  - Responsible handling of medications
  - Adherence with all elements of the treatment plan, including recovery orient activities, psychotherapy, and/or psychosocial modalities
  - Abstinence from illicit drug use

Has the prescribing physician read the attestation statement? ☐ **YES** ☐ **NO**

Does the prescribing physician agree to follow the guidelines set forth by State Medical Boards for opioid addiction treatment? ☐ **YES** ☐ **NO**

Physician Signature _____ Date Signed: _____

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Pregnant Enrollees

(*Complete for pregnant or nursing women only*)

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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