Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Oral Opioid Dependency Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 3 months; Continuation- 6 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Oral Opioid Dependency.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103.

KP-MAS Formulary can be found at Pharmacy | Community Provider Portal | Kaiser Permanente

Clinical Criteria apply to non-preferred products.

Clinical criteria are not required for:

- For a preferred product Suboxone® SL film or buprenorphine/naloxone tablets;
- Members greater 16 years of age or older
- Daily dose less than or equal to 24 mg of buprenorphine

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

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 8 mg/2 mg; 3/day
☐ buprenorphine/naloxone SL film 4 mg/1 mg; 1/day	☐ Zubsolv® SL tab 1.4 mg/0.36 mg; 2/day
☐ Zubsolv® SL tab 0.7 mg/0.18 mg	☐ Zubsolv® SL tab 5.7 mg/1.4 mg; 2/day
☐ Zubsolv® SL tab 2.9 mg/0.71 mg; 2/day	☐ Zubsolv® SL tab 11.4 mg/2.9 mg; 2/day
☐ Zubsolv® SL tab 8.6 mg/2.1 mg; 2/day	

5– Diagnosis/Clinical Criteria

1. Is the member 16 years of age or older?

   □ No □ Yes

2. Does the member meet the criteria for a diagnosis of Opioid Use Disorder (defined by DSM:https://pcssnow.org/resource/opioid-use-disorder-opioid-addiction/)?

   □ No □ Yes

3. Has the member's pregnancy been confirmed by a positive laboratory test?

   □ No □ Yes

   - Buprenorphine mono-product will only be covered for pregnant women for a maximum of 10 months. Document expected date of delivery: _____

4. Is the request for a non-preferred product?

   □ No □ Yes

   If yes, please provide medical necessity information and the reason why a non-preferred product is required. Include details for adverse reactions to combination products:

   _____

   _____

***Note: Daily doses >24mg will deny

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**