Michigan Department of Health and Human Services (MDHHS)
Prior Authorization Request
Medication Assisted Treatment (MAT) for Office Based Opioid Addiction Treatment
With OPIOID PARTIAL AGONISTS (Example: Bunavail, Suboxone, Subutex, Zubsolv, etc.)

General Instructions:

- All questions must be answered for the authorization to be processed.
- Concurrent use of other addictive medications (i.e., benzodiazepines, stimulants) is not recommended. Coordination of care and treatment with other providers/prescribers is expected.
- All requests must be accompanied by the date the **Michigan Automated Prescription System (MAPS)** was last reviewed for the beneficiary. It must be within 30 days of the request. MAPS can be accessed at https://michigan.pmpaware.net/login.
- Requests submitted by Physician Assistants (PAs) and Nurse Practitioners (NPs) must include the PA or NP name, NPI, xDEA number and xDEA expiration date. PAs and NPs must also submit the collaborating physician's name and xDEA number.
- **Pregnant patients**: The "All Pregnant Patients" section must be completed for both initiation and renewal of therapy requests in addition to other requested information.
- Opioid partial agonists used for opioid dependence are not covered by Michigan Department of Health and Human Services for pain management.

Requests for *Initiation of Therapy by the Prescriber* Instructions:

1. **Induction**: appropriate detoxification/induction is expected to take place prior to start of MAT
2. **Duration of authorization:** one year
3. **Quantity/Maximum dose:** Must submit explanation if dose above maximum is requested.
   Suboxone (buprenorphine/naloxone): 24/6 mg/day
   Subutex (buprenorphine): 24 mg/day
   Zubsolv (buprenorphine/naloxone): 17.2/4.2 mg/day
   Bunavail (buprenorphine/naloxone): 12.6/2.1 mg/day
4. **Counseling**: Treatment-naïve patients must be in treatment with a psychiatrist or certified addiction specialist. Narcotics Anonymous/Alcoholics Anonymous for a patient that is treatment-naïve is not sufficient when initiating treatment. Certification needed to obtain a xDEA certificate is not adequate alone.
5. **Tapering**: It is expected that tapering will be considered and attempted, if possible, during the authorization period. Each patient, in collaboration with the prescribing provider, must assess this during the authorization period.

Requests for *Renewal of Therapy by the Prescriber* Instructions:

1. There is no life time limit for treatment.
2. Requests for treatment beyond one year are reviewed on a case-by-case basis.
3. Compliance with all aspects of treatment (plan of care and use of partial agonist, opioid abstinence, office visit attendance, and counseling participation) must be reported with all renewal requests.
4. A Urine Drug Screen (UDS) must be submitted with all renewal requests (required to be less than 30 days old) and must include testing for the drug being used in MAT. An explanation for the absence of the treating drug and any positive findings must be provided. **Only UDS from commercial labs with printed report will be accepted. The UDS must include drugs of abuse and metabolites of buprenorphine. Handwritten UDS will not be accepted.**
5. Requests for doses equal to or greater than the maximum daily dose must be explained for renewals beyond one year. In accordance with policy, it is anticipated that the patient will be treated with the lowest medically appropriate dose (which often times is 8 mg or lower).

Requests for *Transfer of Care* Instructions: Complete the ***Initiation of Therapy*** section of fax form. Transfer of care request is not considered a renewal.

Submit requests to:
Magellan Medicaid Administration
11013 W Broad Street Suite 500, Glen Allen, VA 23060
Fax: 888-603-7696 Phone: 877-864-9014
This form is available at michigan.fhsc.com → Providers → Forms

Revision Date: 07/2017

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All information addressed on this form must be provided for consideration of approval.
Incomplete requests will not be considered for approval and will be returned. Completed requests may be resubmitted at any time.

Beneficiary Information

LAST NAME: | **FIRST NAME:**

ID NUMBER: | **DATE OF BIRTH:** – –

GENDER: MALE ☐ FEMALE ☐ | **PREGNANT:** NO ☐ YES ☐ Expected Delivery Date:

(If yes, complete the ***Pregnant Patients*** section; If no and post-partum, indicate delivery date_____)

Prescriber Information

LAST NAME: | **FIRST NAME:**

PLEASE SELECT ONE: ☐ MD ☐ DO ☐ PA ☐ NP **(PAs and NPs must submit the collaborating physician's name and xDEA #)**

NPI NUMBER: | **SPECIALTY:**

xDEA #: - | **xDEA # EXP:** – –

COLLABORATING PHYSICIAN NAME: | **COLLABORATING PHYSICIAN xDEA #:** -

PHONE NUMBER: – – | **FAX NUMBER:** – –

Person Completing Form

LAST NAME: | **FIRST NAME:**

TITLE:

PHONE NUMBER: – – | **FAX NUMBER:** – –

(NOTE MDHHS DOSE AND QUANTITY LIMITS IN INSTRUCTIONS, ITEM #3)

Drug Name	Strength	Quantity Per Day	Duration Of Treatment

Explanation of Doses Requested Above Maximum:

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Magellan Rx MANAGEMENT

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All boxes within the appropriate treatment course must be completed

Initiation of Therapy Request by the Prescriber

(Transfer of care request is considered an initial request by the prescriber that has accepted the transfer of care)

1. Requested Start Date: _____
2. Diagnosis is confirmed as opioid use disorder (not pain management). ☐ Yes ☐ No
3. Established Physician/Patient relationship with documented face-to-face History and Physical completed by the prescribing provider. ☐ Yes ☐ No
4. Patient has signed an informed consent form or treatment contract. ☐ Yes ☐ No
5. Has a Michigan Automated Prescription Service (MAPS) report been obtained and reviewed (**https://michigan.pmpaware.net/login**)**?** ☐ Yes ☐ No

   Date of the Review: _____
6. Has the patient been referred for active formal substance abuse counseling to begin within 30 days? ☐ Yes ☐ No

   Name of counselor or counseling center/organization: _____

Renewal of Therapy Request by the Prescriber

(Transfer of care request is not considered a renewal; please complete the *Initiation of Therapy* section)

Submit a urine drug screen (UDS) less than 30 days old with request.

1. Diagnosis is confirmed as opioid use disorder (not pain management). ☐ Yes ☐ No
2. Has tapering been attempted? ☐ Yes ☐ No

   If tapering has not been attempted, please explain _____

   _____
3. Has the patient been compliant with doctor's appointments and treatment plan? ☐ Yes ☐ No
4. Has the patient been compliant with counseling? ☐ Yes ☐ No

Pregnant Patients (Initial and Renewal)

Opioid dependent pregnant women are considered a high risk pregnancy. All such cases require OB/GYN directed supervision. Collaboration between providers is expected, including anticipation of neonatal abstinence syndrome at the time of delivery.

1. Document the name of the OB/GYN following this high risk pregnancy.

   _____ ☐ MD ☐ DO
2. Is the OB/GYN aware of the proposed treatment for opioid use disorder for this patient? ☐ Yes ☐ No

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