This Update has been revised since its original publication. The fax number listed on page 2 and the Prior Authorization Drug Attachment for Singulair completion instructions and form in Attachments 1 and 2 have changed.

ForwardHealth
Wisconsin serving you

Update
December 2009

No. 2009-89

Affected Programs: BadgerCare Plus, Medicaid, SeniorCare
To: Blood Banks, Dentists, Dispensing Physicians, Federally Qualified Health Centers, Hospital Providers, Narcotic Treatment Services, Nurse Practitioners, Nursing Homes, Pharmacies, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, HMOs and Other Managed Care Programs

Changes to Pharmacy Policies Occurring in January 2010

This *ForwardHealth Update* describes changes to covered pharmacy services and policies for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Core Plan, Medicaid, and SeniorCare.

ForwardHealth will be making changes to covered pharmacy services and policies for members enrolled in the BadgerCare Plus Standard Plan, the BadgerCare Plus Core Plan, Medicaid, and SeniorCare. Policies and procedures in this *ForwardHealth Update* do not apply to members enrolled in the BadgerCare Plus Benchmark Plan.

Changes for Members Enrolled in the BadgerCare Plus Core Plan

Copayment

Effective for dates of service (DOS) on and after January 1, 2010, copayment amounts for drugs for members enrolled in the Core Plan will change. Copayment for drugs covered by the Core Plan will be the following:

- Up to $4.00 per generic prescription.
- Up to $8.00 per brand name prescription.

There is a monthly maximum of $24.00 per member, per provider.

Copayment for members enrolled in the Core Plan was previously up to $5.00 per prescription, per provider, with a monthly maximum of $20.00 per member, per provider.

Under the Core Plan, a provider has the right to deny services if the member fails to make his or her copayment.

Cozaar®

Effective for DOS on and after January 1, 2010, Cozaar® will be added as a covered drug for members enrolled in the Core Plan. Cozaar® will be covered until generic losartan becomes available. At that time, only generic losartan will be covered for members enrolled in the Core Plan.

Cozaar® will be added to the BadgerCare Plus Core Plan National Drug Code List. Providers may find National Drug Codes for Cozaar® on the BadgerCare Plus Core Plan National Drug Code List on the Pharmacy page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/*.

Singulair®

Effective for DOS on and after January 6, 2010, Singulair® 10 mg will be a diagnosis-restricted drug for members enrolled in the Core Plan. The allowable diagnosis codes for Singulair® 10 mg are 493.00-493.92 (Asthma). Prior authorization (PA) is required for use of Singular® 10 mg outside the approved diagnosis. Singulair® 10 mg is the only

strength of the drug that will be covered for Core Plan members.

Allergic rhinitis is the only diagnosis outside the diagnosis of asthma for which providers may submit PA requests for members enrolled in the Core Plan. Prior authorization requests will not be approved for any other diagnosis. Singulair® 10 mg will be a noncovered drug if the member does not meet the diagnosis restriction for asthma or meet the PA requirements for allergic rhinitis. Core Plan members do not have appeal rights for noncovered drugs.

ForwardHealth has created the Prior Authorization Drug Attachment for Singulair®, F-00204 (01/10), for use when the drug requires PA for allergic rhinitis. Prior authorization requests for members enrolled in the Core Plan may be submitted on the Portal, on paper by fax to (608) 221-0885, or by mail to the following address:

ForwardHealth
Prior Authorization
6406 Bridge Rd
Ste 88
Madison WI 53784-0088

Providers may refer to Attachments 1 and 2 of this *Update* for the Prior Authorization Drug Attachment for Singulair® completion instructions and form. Providers may begin submitting PA requests on paper by fax or mail for Singular® 10 mg for allergic rhinitis for DOS on and after January 6, 2010. Prior authorization requests for Singulair® 10 mg may be submitted using the Portal beginning February 6, 2010.

Clinical Criteria

Criteria for approval of a PA request for Singulair® are the following:

- The member has tried loratadine and experienced an adverse drug reaction or tried loratadine for at least one week and experienced a treatment failure.
- The member has tried cetirizine and experienced an adverse drug reaction or tried cetirizine for at least one week and experienced a treatment failure.
- The member has tried fluticasone and experienced an adverse drug reaction or tried fluticasone for at least two weeks and experienced a treatment failure.
- The member has tried flunisolide and experienced an adverse drug reaction or tried flunisolide for at least two weeks and experienced a treatment failure.
- The member has taken loratadine or cetirizine in combination with fluticasone or flunisolide for at least two weeks and has experienced a treatment failure.

Spiriva®

Effective for DOS on and after January 6, 2010, Spiriva® will no longer be a diagnosis-restricted drug for members enrolled in the Standard Plan, Medicaid, and SeniorCare. Spiriva® continues to be a diagnosis-restricted drug for members enrolled in the Core Plan.

Prior Authorization Changes for Suboxone and Subutex

Effective for DOS on and after January 6, 2010, to monitor appropriate utilization, ForwardHealth will add clinical PA requirements to Suboxone and Subutex for members enrolled in the Standard Plan, Medicaid, and SeniorCare. For members enrolled in the Core Plan, Suboxone and Subutex continue to require PA.

ForwardHealth has revised the Prior Authorization Drug Attachment for Suboxone and Subutex, F-00081 (12/09). This is a new form for members enrolled in the Standard Plan, Medicaid, and SeniorCare and a revised form for members enrolled in the Core Plan.

Prior authorization requests received by ForwardHealth on and after January 5, 2010, for Core Plan members with the Prior Authorization Drug Attachment for Suboxone and Subutex form dated June 2009 will be returned to providers unprocessed.

Prior authorization requests may be submitted on the Prior Authorization Drug Attachment for Suboxone and Subutex via the following:

- Using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system. (Prior authorization requests for members enrolled in the Core Plan cannot be submitted using the STAT-PA system.)
- On the Portal beginning February 6, 2010.
- On paper by fax to (608) 221-8616 or mail to the following address:

  ForwardHealth
  Prior Authorization
  6406 Bridge Rd
  Ste 88
  Madison WI 53784-0088

Prior authorization requests for Suboxone and Subutex will be approved for a maximum of 183 days per request for up to a maximum of two years.

Prior authorization requests for Suboxone and Subutex will not be approved for use outside treatment for opioid dependence.

Providers may refer to Attachments 3 and 4 for the Prior Authorization Drug Attachment for Suboxone and Subutex completion instructions and form.

Clinical Criteria

Criteria for approval of a PA request for Suboxone and Subutex are the following:

- The member is 16 years of age or older.
- If the member is female, she cannot be nursing.
- The drug is being prescribed by a physician who has obtained a DATA 2000 waiver.
- The member is not taking other opioids, tramadol, or carisoprodol.
- The member does not have untreated or unstable psychiatric conditions that may interfere with compliance.

For Subutex, the member must be pregnant, or the member must have a documented allergy to naloxone.

Prior Authorization Requests for Phase II of the Preferred Drug List May Be Submitted on the ForwardHealth Portal

The following fall 2009 Preferred Drug List (PDL) Phase II PA forms are now available for providers to complete and submit PA requests using the Portal:

- The Prior Authorization/Preferred Drug List (PA/PDL) for Antiemetics, Cannabinoids, F-00194 (11/09).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Elidel® and Protopic®, F-11303 (11/09).
- The Prior Authorization/Preferred Drug List (PA/PDL) for Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Including Cyclo-oxygenase Inhibitors, F-11077 (11/09).

Prior authorization requests for these drugs may be submitted via the Portal immediately.

For More Information

For more information about changes listed in this *Update*, providers may refer to the ForwardHealth Online Handbook on the Portal or the ePocrates Web site at *www.epocrates.com/*.

Information Regarding Managed Care Organizations

This *Update* contains fee-for-service policy for members enrolled in Medicaid and BadgerCare Plus who receive pharmacy services on a fee-for-service basis only. Pharmacy services for Medicaid members enrolled in the Program of All-Inclusive Care for the Elderly (PACE) and the Family

Care Partnership are provided by the member's managed care organization (MCO). Medicaid and BadgerCare Plus HMOs must provide at least the same benefits as those provided under fee-for-service.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at *www.forwardhealth.wi.gov/*.

P-1250

ATTACHMENT 1
Prior Authorization Drug Attachment for Singulair® Completion Instructions

(A copy of the "Prior Authorization Drug Attachment for Singulair® Completion Instructions" is located on the following pages.)

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FORWARDHEALTH
PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SINGULAIR®
COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting a PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Attach the completed Prior Authorization Drug Attachment for Singulair® form, F-00204, to the Prior Authorization Request Form (PA/RF), F-11018, and physician prescription (if necessary) and send it to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

Note: The only strength of Singulair® for which PA may be requested is Singulair® 10 mg.

SECTION I — MEMBER INFORMATION

Element 1 — Name — Member
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Element 3 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
This element is populated with Singulair®.

Element 5 — Drug Strength
This element is populated with 10 mg.

Element 6 — Date Prescription Written
Enter the date that the prescription was written.

Element 7 — Refills
Enter the number of refills.

Element 8 — Directions for Use
Enter the directions for use of the drug.

Element 9 — Name — Prescriber
Enter the name of the prescriber.

Element 10 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier of the prescriber.

Element 11 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 12 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

SECTION III — CLINICAL INFORMATION

This section must be completed for all requests for Singulair®.

Element 13 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 14
Indicate whether or not the member has tried loratadine and experienced an adverse drug reaction or tried loratadine for at least one week and experienced a treatment failure. If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates loratadine was taken in the space provided.

Element 15
Indicate whether or not the member has tried cetirizine and experienced an adverse drug reaction or tried cetirizine for at least one week and experienced a treatment failure. If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates cetirizine was taken in the space provided.

Element 16
Indicate whether or not the member has tried fluticasone and experienced an adverse drug reaction or tried fluticasone for at least two weeks and experienced a treatment failure. If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates fluticasone was taken in the space provided.

Element 17
Indicate whether or not the member tried flunisolide and experienced an adverse drug reaction or tried flunisolide for at least two weeks and experienced a treatment failure. If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates flunisolide was taken in the space provided.

Element 18
Indicate whether or not the member has taken loratadine or cetirizine in combination with fluticasone or flunisolide for at least two weeks and experienced a treatment failure. If yes, list the drugs involved, the specific details about the treatment failure, and the approximate dates the drugs were taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE

The physician must read and sign the attestation statement for consideration of the PA request.

Element 19 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 20 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — ADDITIONAL INFORMATION

Element 21
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

ATTACHMENT 2
Prior Authorization Drug Attachment for Singulair®

(A copy of the "Prior Authorization Drug Attachment for Singulair®" is located on the following pages.)

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DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00204 (01/10)

STATE OF WISCONSIN
DHS 107.10(2), 152.06(3)(h), Wis. Admin. Code
DHS 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SINGULAIR®

Instructions: Print or type clearly. Refer to the Prior Authorization Drug Attachment for Singulair® Completion Instructions, F-00204A, for more information.

The only strength of Singulair® for which prior authorization may be requested is Singulair® 10 mg.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number	3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name Singulair®	5. Drug Strength 10 mg
6. Date Prescription Written	7. Refills

8. Directions for Use

9. Name — Prescriber	10. National Provider Identifier (NPI) — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

14. Has the member tried loratadine and experienced an adverse drug reaction or tried loratadine for at least one week and experienced a treatment failure? ❑ Yes ❑ No

If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates loratadine was taken in the space provided.

15. Has the member tried cetirizine and experienced an adverse drug reaction or tried cetirizine for at least one week and experienced a treatment failure? ❑ Yes ❑ No

If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates cetirizine was taken in the space provided.

16. Has the member tried fluticasone and experienced an adverse drug reaction or tried fluticasone for at least two weeks and experienced a treatment failure? ❑ Yes ❑ No

If yes, list the specific details about the adverse drug reaction or the treatment failure and the approximate dates fluticasone was taken in the space provided.

Continued

SECTION III — CLINICAL INFORMATION (Continued)

17. Has the member tried flunisolide and experienced an adverse drug reaction or tried flunisolide for at least two weeks and experienced a treatment failure? ❑ Yes ❑ No

If yes, list the specific details about the adverse drug reaction or treatment failure and the approximate dates flunisolide was taken in the space provided.

18. Has the member taken loratadine or cetirizine in combination with fluticasone or flunisolide for at least two weeks and experienced a treatment failure? ❑ Yes ❑ No

If yes, list the drugs involved, the specific details about the treatment failure, and the approximate dates the drugs were taken in the space provided.

SECTION IV — AUTHORIZED SIGNATURE (Include authorization statement or attestation, if needed.)

19. **SIGNATURE** — Prescriber	20. Date Signed

SECTION V — ADDITIONAL INFORMATION

21. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

ATTACHMENT 3
Prior Authorization Drug Attachment for Suboxone and Subutex Completion Instructions

(A copy of the "Prior Authorization Drug Attachment for Suboxone and Subutex Completion Instructions" is located on the following pages.)

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FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SUBOXONE AND SUBUTEX COMPLETION INSTRUCTIONS

ForwardHealth requires certain information to enable the programs to authorize and pay for medical services provided to eligible members.

Members of ForwardHealth are required to give providers full, correct, and truthful information for the submission of correct and complete claims for reimbursement. This information should include, but is not limited to, information concerning enrollment status, accurate name, address, and member identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about program applicants and members is confidential and is used for purposes directly related to ForwardHealth administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or payment for the services.

The use of this form is mandatory when requesting a PA for certain drugs. If necessary, attach additional pages if more space is needed. Refer to the applicable service-specific publications for service restrictions and additional documentation requirements. Provide enough information for ForwardHealth to make a determination about the request.

Attach the completed Prior Authorization Drug Attachment for Suboxone and Subutex form, F-00081, to the Prior Authorization Request Form (PA/RF), F-11018, and physician prescription (if necessary) and send it to ForwardHealth. Providers may submit PA requests by fax to ForwardHealth at (608) 221-8616 or by mail to the following address:

ForwardHealth
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Providers should make duplicate copies of all paper documents mailed to ForwardHealth. The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — MEMBER INFORMATION

Element 1 — Name — Member
Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS.

Element 2 — Member Identification Number
Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

Element 3 — Date of Birth — Member
Enter the member's date of birth in MM/DD/CCYY format.

SECTION II — PRESCRIPTION INFORMATION

Element 4 — Drug Name
Check the name of drug prescribed.

Element 5 — Drug Strength
Check the strength of drug in milligrams.

Element 6 — Date Prescription Written
Enter the date that the prescription was written.

Element 7 — Refills
Enter the number of refills.

Element 8 — Directions for Use
Enter the directions for use of the drug.

Element 9 — Name — Prescriber
Enter the name of the prescriber.

Element 10 — National Provider Identifier (NPI) — Prescriber
Enter the 10-digit National Provider Identifier (NPI) of the prescriber.

Element 11 — Address — Prescriber
Enter the address (street, city, state, and ZIP+4 code) of the prescriber.

Element 12 — Telephone Number — Prescriber
Enter the telephone number, including area code, of the prescriber.

SECTION IIIA — CLINICAL INFORMATION

This section must be completed for all requests for Suboxone and Subutex.

Element 13 — Diagnosis Code and Description
Enter the appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code and description most relevant to the drug requested. The ICD-9-CM diagnosis code must correspond with the ICD-9-CM description.

Element 14
Indicate whether or not the member is 16 years of age or older.

Element 15
Indicate whether or not the member is female.

Element 16
Indicate whether or not the member is currently nursing.

Element 17
Indicate whether or not the physician is a Drug Addiction Treatment Act (DATA 2000)-waived physician. If yes, indicate the physician's "X" DEA number in the space provided. Check no if the physician does not participate in this program.

Element 18
Indicate whether or not the member is taking other opioids, tramadol, or carisoprodol. If yes, list the drugs taken and the dates they were taken in the space provided.

Element 19
Indicate whether or not the member has any untreated or unstable psychiatric conditions that may interfere with compliance. If yes, list the condition in the space provided.

SECTION IIIB — CLINICAL INFORMATION (Complete for Subutex requests only.)

Element 20
Indicate whether or not the member is pregnant.

Element 21
Indicate whether or not the member is allergic to naloxone. If yes, describe the allergic reaction in the space provided.

SECTION IV — ATTESTATION

The physician must read and sign the attestation statement for consideration of the PA request.

Element 22
Indicate whether or not the prescribing physician has read the attestation statement.

Element 23
Indicate whether or not the prescribing physician agrees to follow the guidelines set forth by State Medical Boards for opioid addiction treatment.

Element 24 — Signature — Prescriber
The prescriber is required to complete and sign this form.

Element 25 — Date Signed
Enter the month, day, and year the form was signed in MM/DD/CCYY format.

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

Element 26 — National Drug Code
Enter the appropriate 11-digit National Drug Code for each drug.

Element 27 — Days' Supply Requested
Enter the requested days' supply.

Note: ForwardHealth will not approve a days' supply greater than 183 days.

Element 28 — NPI
Enter the NPI of the pharmacy provider.

Element 29 — Date of Service
Enter the requested first date of service (DOS) for the drug. For STAT-PA requests, the DOS may be up to 31 days in the future or up to 14 days in the past.

Element 30 — Patient Location
Enter the appropriate National Council for Prescription Drug Programs patient location code designating where the requested item would be provided/performed/dispensed.

Code	Description
0	Not Specified
1	Home
4	Long Term/Extended Care
7	Skilled Care Facility
10	Outpatient

Element 31 — Assigned PA Number
Indicate the PA number assigned by the STAT-PA system.

Element 32 — Grant Date
Indicate the date the PA was approved by the STAT-PA system.

Element 33 — Expiration Date
Indicate the date the PA expires as assigned by the STAT-PA system.

Element 34 — Number of Days Approved
Indicate the number of days for which the STAT-PA request was approved by the STAT-PA system.

SECTION VI — ADDITIONAL INFORMATION

Element 35
Indicate any additional information in the space provided. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

ATTACHMENT 4
Prior Authorization Drug Attachment for Suboxone and Subutex

(A copy of the "Prior Authorization Drug Attachment for Suboxone and Subutex" is located on the following pages.)

DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00081 (12/09)

STATE OF WISCONSIN
DHS 107.10(2), 152.06(3)(h), Wis. Admin. Code
DHS 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR SUBOXONE AND SUBUTEX

Instructions: Print or type clearly. Refer to the Prior Authorization Drug Attachment for Suboxone and Subutex Completion Instructions, F-00081A, for more information.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Suboxone and Subutex form signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name (Check One) ❑ Suboxone ❑ Subutex

5. Drug Strength (Check Strength[s]) ❑ 2 mg ❑ 8 mg

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier (NPI) — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION IIIA — CLINICAL INFORMATION (Required for all requests.)

13. Diagnosis Code and Description

14. Is the member 16 years of age or older? ❑ Yes ❑ No

15. Is the member female? ❑ Yes ❑ No

16. If female, is the member nursing? ❑ Yes ❑ No

17. Does the physician have a valid Drug Addiction Treatment Act (DATA 2000) waiver allowing him or her to prescribe Suboxone and Subutex for opioid dependence? ❑ Yes ❑ No

    If yes, enter the physician's "X" DEA number in the space provided.

18. Is the member taking any other opioids, tramadol, or carisoprodol? ❑ Yes ❑ No

    If yes, list the drugs taken and the dates they were taken in the space provided.

19. Does the member have any untreated or unstable psychiatric conditions that may interfere with compliance? ❑ Yes ❑ No

    If yes, list the condition in the space provided.

Continued

SECTION IIIB — CLINICAL INFORMATION (Complete for Subutex request only.)

20. Is the member pregnant?	❑ Yes	❑ No
21. Does the member have a documented allergy to naloxone?	❑ Yes	❑ No

If yes, describe the allergic reaction in the space provided.

SECTION IV — ATTESTATION

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

- The patient should receive opioids from only one physician and/or 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 toxicologic testing for drugs of abuse and therapeutic drug levels.
  - Number and frequency of all prescription refills.
  - Reasons for which drug therapy may be discontinued.
- Continuation or modification of opioid therapy should depend on the physician's evaluation of progress toward stated treatment objectives such as:
  - Absence of toxicity.
  - Absence of medical or behavioral adverse effects.
  - Responsible handling of medications.
  - Compliance with all elements of the treatment plan, including recovery-oriented activities, psychotherapy, and/or psychosocial modalities.
  - Abstinence from illicit drug use.

22. Has the prescribing physician read the attestation statement?	❑ Yes	❑ No
23. Does the prescribing physician agree to follow the guidelines set forth by State Medical Boards for opioid addiction treatment?	❑ Yes	❑ No

24. **SIGNATURE** — Prescriber	25. Date Signed

SECTION V — FOR PHARMACY PROVIDERS USING STAT-PA

26. National Drug Code (11 Digits)	27. Days' Supply Requested (Up to 183 Days)

28. NPI

29. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

30. Patient Location (Use patient location code "0" [Not specified], "1" [Home], "4" [Long Term / Extended Care], "7" [Skilled Care Facility], or "10" [Outpatient].)

31. Assigned PA Number

32. Grant Date	33. Expiration Date	34. Number of Days Approved

SECTION VI — ADDITIONAL INFORMATION

35. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.