Brixadi + Sublocade Prior Authorization Form

Incomplete forms will not be reviewed

Maryland Medicaid Pharmacy Program
Fax: (866) 440-9345
Phone: (800) 932-3918

Date (mm/dd/yyyy): _____

Patient Information

Name: _____ DOB (mm/dd/yyyy): _____ ❑ Age≥18 years

Medicaid Assistance Number: _____ ❑ M ❑ F Height: _____ Weight: _____

Prescriber Information

Name: _____ NPI: _____

Contact Person: _____ Phone: _____ Fax: _____

Prescription Information ❑ Initial PA Request ❑ Renewal Request

❑ **Diagnosis:** Moderate to severe Opioid Use Disorder (OUD)

Sublocade

❑ Patient **not** currently taking buprenorphine but has received/will receive an initial dose (e.g. 4 mg) of transmucosal buprenorphine before administering the first injection of Sublocade. **or**

❑ Patient is transitioning from transmucosal buprenorphine product equivalent to 8-24mg of buprenorphine daily **or**

- ❑ Injection# 1. Dose: _____
- ❑ Injection# 2. Dose: _____
  - *Second injection can be given as early as 1 week and up to 1 month after the first injection*

❑ Patient currently being treated with buprenorphine injection

- ❑ Maintenance Treatment Dose: _____ Quantity limit:1 syringe (any strength) / 28 days

Initial authorization approval for 90 days. Renewal authorization for 12 months.

Brixadi

❑ Patient has initiated treatment with a single dose of a transmucosal buprenorphine (e.g. 4mg) **or**
❑ Patient currently being treated with buprenorphine

- ❑ Weekly Injection Dose: _____ Quantity limit: 32 mg / 7 days
- ❑ Monthly Injection Dose: _____ Quantity limit: 128mg / 28 days

Authorization	Brixadi Weekly	Brixadi Monthly
Initial	28 days	90 days
Renewal	28 days	12 months

I attest that:

❑ The benefits of the treatment outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge
❑ The MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original.

Prescriber's Signature: _____ Date (mm/dd/yyyy): _____