Office of Pharmacy Services
Fax: (866) 440-9345
Phone: (800) 932-3918

Sublocade
Prior Authorization Form

Maryland
DEPARTMENT OF HEALTH

Patient's Information: **Date:** _____

Name: _____ DOB: _____

Participant's Maryland Medicaid Number: _____

Prescriber's Information:

Name: _____NPI #: _____

Phone #: _____ Fax #: _____

Contact Person for this Request:

Name: _____ Phone: _____ Fax: _____

Medication: _____ Strength: _____ Quantity: _____ Refills: _____

Directions for Use: _____

Sublocade Criteria

☐ Must be 18 years old

☐ Diagnosis of moderate to severe Opioid Use Disorder (OUD)

☐ Has initiated treatment with a transmucosal buprenorphine-containing product delivering the equivalent of 8 to 24mg of buprenorphine daily, followed by dose adjustment for a minimum of 7 days

Other Information:

- Quantity limit (QL) - one injection (any dose) every 30 days
- Initial authorization approval for 90 days
- Renewal authorization for 12 months

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber's Signature_____ Date_____

Fax this completed form to 866-440-9345, once all the required information has been provided. **Incomplete forms will not be reviewed**.

Internal Use only- Information below is to be completed by the PA pharmacist

For Sublocade Criteria ☐ OUD diagnosis and criteria met for initial treatment with transmucosal buprenorphine product ☐ Approved ☐ Denied