

## MOLINA HEALTHCARE Service Authorization (SA) Form Oral Buprenorphine Products

## Oral Buprenorphine products do not require a SA if:

- It is for a preferred product Suboxone® SL film or buprenorphine/naloxone tablets
- If the member is 16 or older
- If the prescribed dosage is 24 mg/day or less

Length of Authorization: 3 Months (Initial SA), 6 months (Maintenance SA)

If the following information is not complete, correct, and legible, the SA process could be delayed. Please use one form per member.

## **MEMBER INFORMATION**

Last Name:	First Name:													
Molina ID Number:	Date of Birth:													
Gender  Male Female	Weight in Kilograms:													
PRESCRIBER INFORMATION														
Last Name:	First Name:													
NPI Number:	Specialty:													
Phone Number:	Fax Number:													
(Form continued on next page.)														

Molinahealthcare.com

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## MOLINA SA Form: Oral Buprenorphine Products

Member's Last Name	Member's First Name														
DRUG INFORMATION															
OPIOID DEPENDENCY – ORAL BUPRENORPH The Board of Medicine reg 18VAC85-21-150: Dependence of the control of the	INE OSES GREATER THAN 24 MG/DAY WILL DENY.														
Drug Name/Form:															
Strength:															
Quantity per day:															
Maximum Quantities for Dose Optimization (No	on-Preferred Drugs)														
buprenorphine/naloxone SL film 2 mg/0.5 mg; 3/d	ay														
buprenorphine/naloxone SL film 4 mg/1 mg; 1/day	buprenorphine/naloxone SL film 8 mg/2 mg;3/day														
Zubsolv® SL tab 0.7 mg/0.18 mg; 2/day	Zubsolv® SL tab 1.4 mg/0.36 mg;2/day														
Zubsolv® SL tab 2.9 mg/0.71 mg; 2/day	Zubsolv® SL tab 5.7 mg/1.4 mg; 2/day														
Zubsolv® SL tab 8.6 mg/2.1 mg; 2/day	Zubsolv® SL tab 11.4 mg/2.9 mg;2/day														
TREATMENT INFORMATION															
	s Regulations Governing Prescribing of Opioids and														
Buprenorphine  1. Member's programmy has been confirmed by a	positivo Laboratory toot														
<ol> <li>Member's pregnancy has been confirmed by a</li> <li>Yes  No  </li> </ol>	positive Laboratory test														
	vered for pregnant women for a maximum of 10														
Document expected date of delivery:															
(IF YES, PLEASE SIGN AND SUBMIT, NO	FURTHER INFORMATION REQUIRED unless a														
non-preferred/non-formulary drug is prescribed Section if a non-formulary drug is prescribed	ed. See the Non-Preferred/Non-Formulary Drugs .)														
2. Member meets criteria for a diagnosis of Opioio															
(defined by DSM 5: <a href="https://pcssnow.org/resour.">https://pcssnow.org/resour.</a>	ce/opioid-use-disorder-opioid-addiction/).														
Yes No															
<ol> <li>Member is 16 years of age or older?</li> <li>Yes ☐ No ☐</li> </ol>															
(Form continued on next page.)															

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NC	N-PF	REF	ERR	RED/	/NOI	N-F(	ORM	IUL	ARY	DF	RUG	S									
1.	Non-Preferred agents require documentation as to why the member cannot be prescribed a preferred agent. Include details. A completed FDA MedWatch Form is required to be attached for adverse reactions to combination products.												-								
Ву	escri signa curat	ature	e, th	e ph	nysic	ian	conf	irms			ove i	nfc	orma	tion	is		Da	ite			

Please include ALL requested information; incomplete forms will delay the SA process. Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be **FAXED to (844) 278-5731**, or you may call (800) 424-4518 (TTY: 711).