mercy care

Fax completed prior authorization request form to 855-247-3677 (Integrated population) or 855-246-7736 (SMI Non-Title population) or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/pharmacy.html

Sublocade and Brixadi
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information				
☐ **Brixadi**	☐ **Sublocade**			
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): Yes ☐ No ☐	Diagnosis:	ICD-10 Code:		
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request
Directions for Use:	Strength:	Dosage Form:		
	Quantity:	Day Supply:	Duration of Therapy/Use:	
What medication(s) has the member tried and failed for this diagnosis? Please specify below.				

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information					
Does member have severe Opioid Use Disorder (OUD) as defined by DSM-5 OUD Diagnostic Tool?	☐ Yes	☐ No	Does member have a demonstrated history of non-adherence to oral medications?	☐ Yes	☐ No
Is member currently maintained on 8mg-24mg per day dose of oral, sublingual OR transmucosal buprenorphine product equivalent prior to initiation of Brixadi or Sublocade?	☐ Yes	☐ No	Will member receive supplemental, oral, sublingual OR transmucosal buprenorphine?	☐ Yes	☐ No
Is member receiving psychosocial interventions as part of a comprehensive medication assisted treatment (MAT) program?	☐ Yes	☐ No	Is Brixadi or Sublocade being requested due to circumstances other than non-adherence to oral medications? Please document circumstances below.	☐ Yes	☐ No
Has prescriber checked the Arizona State Board of Pharmacy CSPMP database prior to each monthly injection?	☐ Yes	☐ No	Is Brixadi or Sublocade dosing in accordance with FDA approved labeling?	☐ Yes	☐ No
☐ **Renewal Requests ONLY**					
Is there documentation that member has experienced a positive clinical response to Brixadi or Sublocade therapy, as defined by	☐ Yes	☐ No	Has member OR will member receive supplemental, oral, sublingual OR transmucosal buprenorphine for greater	☐ Yes	☐ No

provider?			than 6 weeks after Brixadi or Sublocade therapy initiation?		
Is member receiving psychosocial interventions as part of a comprehensive medication assisted treatment (MAT) program?	☐ Yes	☐ No	Is Brixadi or Sublocade being requested due to circumstances other than non-adherence to oral medications? Please document circumstances below.	☐ Yes	☐ No
Has prescriber checked the Arizona State Board of Pharmacy CSPMP database prior to each monthly injection of Brixadi or Sublocade?	☐ Yes	☐ No	Is Brixadi or Sublocade dosing in accordance with FDA approved labeling?	☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-564-5465 to check the status of a request.