



Fax completed prior authorization request form to 800-854-7614 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/chp-forproviders/pharmacy

Sublocade 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:		Height:			
				<input type="checkbox"/> Male <input type="checkbox"/> Female					
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									
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:				<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> New request		<input type="checkbox"/> 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									
<input type="checkbox"/> Standard – (24 hours)			<input type="checkbox"/> 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?			<input type="checkbox"/> Yes <input type="checkbox"/> No		Does member have a demonstrated history of non-adherence to oral medications?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is member currently maintained on 8mg-24mg per day dose of oral, sublingual OR transmucosal buprenorphine product equivalent for at least 7 days prior to start of ER buprenorphine injection?			<input type="checkbox"/> Yes <input type="checkbox"/> No		Will member receive supplemental, oral, sublingual OR transmucosal buprenorphine?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is member receiving psychosocial interventions as part of a comprehensive medication assisted treatment (MAT) program?			<input type="checkbox"/> Yes <input type="checkbox"/> No		Does prescriber meet DATA 2000 requirements AND has been assigned a unique ID number specific to prescription of medication assisted therapy (DEA-X)?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has prescriber checked the Arizona State Board of Pharmacy CSPMP database prior to each monthly injection?			<input type="checkbox"/> Yes <input type="checkbox"/> No		Is Sublocade dosing in accordance with FDA approved labeling: 300mg SubQ monthly for first 2 months, followed by maintenance dose of 100mg or 300mg monthly?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Renewal Requests ONLY									
<input type="checkbox"/> Is there documentation that member has			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Has member OR will member receive			<input type="checkbox"/> Yes <input type="checkbox"/> No	

experienced a positive clinical response to buprenorphine ER therapy, as defined by provider?			supplemental, oral, sublingual OR transmucosal buprenorphine?		
Is member receiving psychosocial interventions as part of a comprehensive medication assisted treatment (MAT) program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does prescriber meet DATA 2000 requirements AND has been assigned a unique ID number specific to prescription of medication assisted therapy (DEA-X)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has prescriber checked the Arizona State Board of Pharmacy CSPMP database prior to each monthly injection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is Sublocade dosing in accordance with FDA approved labeling: 300mg SubQ monthly for first 2 months, followed by maintenance dose of 100mg or 300mg monthly?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 833-711-0776 to check the status of a request.