BlueCross BlueShield Federal Employee Program

BRIXADI
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Brixadi

(buprenorphine extended-release injection)

NOTE: Form must be completed in its **entirety** for processing

Please select weekly or monthly injections and indicate quantity:

❑Weekly (8mg, 16mg, 24mg, 32mg) - Will the patient need more than 12 syringes every 84 days? ❑Yes* ❑No

***If YES*, please specify the requested quantity: _____ syringes every 84 days**

❑Monthly (64mg, 96mg, 128mg) - Will the patient need more than 3 syringes every 84 days? ❑Yes* ❑No

***If YES*, please specify the requested quantity: _____ syringes every 84 days**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. What is the patient's diagnosis?
   ❑Opioid dependence
   ❑Other diagnosis ***(please specify)***: _____
2. Will Brixadi be taken in combination with another opioid, either long acting (ER/LA/SA) or immediate acting (IR)? ❑Yes* ❑No
   If YES, do you agree the patient will be tapered off other opioids within 30 days? ❑Yes ❑No
3. Is the patient using Brixadi exclusively for pain control? ❑Yes ❑No
4. Is this request for **INITIATION** or **CONTINUATION** of therapy? ***Please select answer below:***

   ❑**INITIATION** of therapy, please answer the following questions:
   a. Will the patient receive counseling and psychosocial support? ❑Yes ❑No
   b. Will the patient be monitored during therapy for signs and symptoms of abuse/misuse as well as compliance and the potential diversion to others? ❑Yes ❑No
   c. Was the patient initially treated with a single dose of a transmucosal buprenorphine product or is already being treated with buprenorphine? ❑Yes ❑No

   ❑**CONTINUATION** of therapy (**PA renewal**), please answer the following questions:
   a. Is Brixadi being used for the maintenance treatment of opioid dependence? ❑Yes ❑No
   b. Has the patient shown signs of opioid dependence-relapse? ❑Yes ❑No
   c. Will the monitoring of therapy and support be continued? ❑Yes ❑No