



**Montana Medicaid
Buprenorphine-containing products for Opioid Substance Use Disorder
Prior Authorization Request Form**

Patient Name:	Patient Medicaid ID#:	Patient DOB:
Provider Name:	Provider DEA# (X-DEA required):	
Provider Phone #:	Provider Fax #:	
Drug/Dose Request (mg)	Daily Directions (i.e. 1 QD)	

Provider attests patient Treatment Plan includes all of the following (please check) and **will be documented** in patient chart (case notes do not need to be sent unless specifically requested):

- Patient is 16 years of age or older.
- Patient assessment/screening supports a diagnosis of **moderate to severe** Opioid SUD (DSM-V Criteria).
- Patient will be referred for counseling assessment and counseling.
- Proposed monitoring plan includes random pill counts and random urine drug screens (to include drugs of abuse and buprenorphine).
- Treatment Contract has been signed by patient
- Pregnant or nursing patient-the following section must be completed:

- If pregnant, EDD: _____
- Treatment provider attests that OB provider has been contacted to establish post-delivery plan (for treatment of neonatal withdrawal syndrome) :
 - OB Provider Name/Phone: _____ / _____ Date Contacted: _____

Limitations (specific product subject to Preferred Drug List requirements):

- 1. Quantity Limits (Ongoing reassessment to establish the lowest effective dose is recommended):**
 - SUBOXONE film 8 mg/2 mg or 2 mg/0.5 mg: Max 3 films daily. *Authorized for 1 year with annual update required.*
 - Buprenorphine SL 2 mg or 8 mg: Max 3 tablets daily. *Authorized only for max 5 days for induction OR duration of pregnancy/nursing.*
- 2. Concurrent opioids, tramadol, or carisoprodol will not be covered with buprenorphine-containing products.**
 - If a patient subsequently discontinues the buprenorphine-containing product, all opioids, tramadol formulations, and carisoprodol will remain on not-covered status. These medications will require Prior Authorization for any future prescriptions. Approval may be granted short-term for an acute injury, hospitalization, or other appropriate diagnosis *only* after the case is reviewed with the treating provider and the provider prescribing the buprenorphine-containing product.

Signature of Provider: _____ Date: _____

**Please complete form and fax to Medicaid Drug Prior Authorization Unit
1-800-294-1350**

Important Notice

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