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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)	

1. **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 ***and patient understands section "B" below.***
   - ☐ Pregnant or nursing patient-complete the following information:

     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):

   A. 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.*

   B. 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.

2. **Consideration will be made to offer patient a naloxone rescue prescription & education: Yes No**
   (Products *available without PA* are Narcan® nasal spray, naloxone vial for injection, naloxone prefilled syringe for injection)

Signature of Provider: _____Date: _____

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

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