

Montana Healthcare Programs

Medication Assisted Treatment (MAT) Form

Patient Name:	Patient Medicaid ID#:	Patient DOB:
Provider Name:	Provider DEA# (X-DEA required):	
Provider Phone #:	Provider Fax #:	

Instructions:

This form is required for Montana Healthcare Program members who receive Medication Assisted Treatment (MAT). Answer the three questions and sign the form below:

Questions:

1. Has the Montana Prescription Drug Registry been reviewed: Yes No
2. Has the member been educated on their outpatient prescription opioid, tramadol, and/or carisoprodol restrictions: Yes No
3. Which medication is the member receiving: Methadone Buprenorphine Containing Product

Important Note:

Concurrent opioids, tramadol, or carisoprodol are not covered for members in Medication Assisted Treatment (MAT).

If a patient subsequently discontinues medication assisted treatment (MAT), 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 this form and fax to Medicaid Pharmacy Program Staff at
1-406-444-1861**

Important Notice

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Anyone who receives this in error should notify us immediately by telephone at (406) 444-2738 and return the original message to us at the address above via U. S. Mail.