



Montana Healthcare Programs

Medication Assisted Treatment (MAT)

Instructions: Complete this form and **fax to Pharmacy Program Staff at (406) 444-1861.**

This form is required for Montana Healthcare Program members who receive MAT in an Opioid Treatment Program (OTP). Please ensure you complete this form in its entirety.

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

Questions

Is the member:

Newly enrolled
 Discontinuing services with your facility

If the member is a newly enrolled member/patient, please answer the 3 questions below. If the member/patient is discontinuing services, please **do not** answer the 3 questions below.

1. Has the Montana Prescription Drug Registry (MPDR) 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 MAT. If a patient subsequently discontinues 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: _____

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