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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