



# 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.

<b>Patient Name</b>	<b>Patient Medicaid ID</b>	<b>Patient DOB</b>
<b>Provider Name</b>	<b>Provider DEA # (X-DEA required)</b>	
<b>Provider Telephone</b>	<b>Provider Fax</b>	

### 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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