Suboxone® and Subutex® Prior Authorization Request Form (MAP- revised 9/22/09)

*Form must be completed, signed and submitted by a physician with a Drug Addiction Treatment Act (DATA) waiver** **(UIN #)***

Approval does not ensure eligibility. Please verify Medicaid eligibility before completing this form.

FAX to **800-365-8835** (toll free)

For **URGENT** Requests Only, FAX to **800-421-9064** (toll free)

For **NURSING FACILITY** Requests Only, FAX to **800-453-2273** (toll free)

MAIL to PA Unit, 14955 Heathrow Forest Pkwy. Houston, TX 77032

RECIPIENT NAME	MAID # (10 digits)	DATE OF BIRTH
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First Health is directed to FAX a response to the following fax number (s):	*Prescriber Fax # (Print Clearly)*	*and /or*	*Pharmacy Fax # (Print Clearly)*

PRESCRIBER Information			
Name		DEA #	
Phone # *(Not fax number)*		** UIN #	
NPI Number		Specialty	

	Drug Requested	Dosage Form	Strength	Quantity	Directions for use	Start Date for this PA	National Drug Code
1	Suboxone®	SL Tab	8mg				
2	Suboxone®	SL Tab	2mg				
3	Subutex®	SL Tab	8mg				
4	Subutex®	SL Tab	2mg				

Patient is enrolled in a formal substance abuse counseling/treatment program	Program Name:
OR	
Patient is being counseled by a psychiatrist or certified addiction specialist	Counselor Name:

Patient has honored all of their scheduled office visits and counseling sessions in a compliant manner	Y N
Patient shows no evidence of dependence on cocaine, alcohol, or other drugs, except nicotine	Y N
I agree to query KASPER on a monthly basis for this patient	Y N Last Query Date____________

** I certify that I have a ***Drug Addiction Treatment Act (DATA) waiver.*** Additionally, I certify that the information stated above is a true statement, made for the purposes of inducing Kentucky Medicaid to offer prescription coverage to this individual for the medication requested above. I understand that First Health Services, on behalf of the Commonwealth, will retain this document and any attached materials for the purposes of possible future audit(s).

Physician Signature ______________________________________ **Date**_______________