



Buprenorphine Products Prior Authorization Request Form

(KY -MAP-82101, revised 2/14/11)

FAX to 800-365-8835

OR MAIL to Pharmacy Department, 1st floor south, 14100 Magellan Plaza, Maryland Heights, MO 63043

For **URGENT** Requests Only, FAX to **800-421-9064**

For **NURSING FACILITY** Requests Only, FAX to **800-453-2273**

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

| | | | | |
|---|--|----------------------------------|--|--------------------------------|
| RECIPIENT NAME | | MEDICAID # | | DATE OF BIRTH |
| | | - - - - - | | |
| Magellan is directed to FAX a response to the following fax number (s): | | Prescriber Fax # (Print Clearly) | | Pharmacy Fax # (Print Clearly) |
| PRESCRIBER Information | | | | |
| Name | | DEA # | | |
| Phone # (Not fax number) | | ** UIN # | | |
| NPI Number | | Specialty | | |

Drug Requested:

Suboxone[®] SL Tab 8mg/2mg Suboxone[®] SL Tab 2mg/0.5mg Suboxone[®] SL Film Tab 8mg/2mg

Suboxone[®] SL Film Tab 2mg/0.5mg buprenorphine SL Tab 8mg buprenorphine SL Tab 2mg

Quantity: _____ Sig: _____ Start date of this PA: _____

*Of note, the initial two months of therapy will be approved for a 10 days supply per prescription only.

**Doses above 32 mg per day will NOT be approved.

- Primary Diagnosis: ICD-9: _____
- Psychosocial Counseling: _____
 - Date of last psychosocial counseling session: _____
 - Has patient been compliant with all sessions? Yes No
- Please provide plan for method and dates (next 3) of psychosocial counseling going forward:
 - Method: _____
 - Dates: (1) _____ (2) _____ (3) _____
- Must submit most current urine drug screen with this form.
- Does patient currently abuse alcohol? Yes No
- Date KASPER last queried for this patient: _____
- Has patient taken opioids in the past 30 days? Yes No
 - If yes, please state reason for opioid use: _____
 - If yes, has patient experienced a relapse in disease? Yes No
- If requesting doses above 24 mg per day, state clinical reason current dosing limits are being exceeded: _____
 - Has patient tried a dose of 24 mg per day? Yes No
 - If yes, provide dates of therapy: _____
- Has a taper dose been tried? Yes No
 - If yes, date patient last tapered: _____
 - Was taper successful? Yes No
 - If not, why? _____
- Has patient been incarcerated or hospitalized in the past 6 months? Yes No
 - If yes, please provide dates of incarceration. _____
 - If yes, please provide dates of hospitalization. _____
- Has patient been convicted of narcotic use while taking a buprenorphine product? Yes No
 - If yes, please provide date of conviction. _____
- Has patient been convicted for the sale of a buprenorphine product? Yes No
 - If yes, please provide date of conviction. _____

** 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 Magellan Medicaid Administration, on behalf of the Commonwealth, will retain this document and any attached materials for the purposes of possible future audit(s).

Physician Signature _____ **Date** _____

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.